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ABSTRACT

This resource manual is designed to assist Alberta teachers in the identification and education of students with emotional disorders and/or mental illnesses. It takes a comprehensive look at six emotional disorders. The first section focuses on eating disorders. It describes the characteristics and symptoms of anorexia nervosa, bulimia nervosa, and binge eating. Risk factors that may trigger the onset of eating disorders are identified, and myths surrounding food, weight, and body image are included. Section 2 presents short descriptions of seven common anxiety disorders, including separation anxiety disorder, overanxious disorder of childhood, post-traumatic stress, acute stress, obsessive compulsive disorder, anxiety disorder due to general medical conditions, and substance-induced anxiety. The following section describes different types of depression in childhood and adolescents. Section 4 presents an overview of the characteristics and causes of schizophrenia. Section 5 defines oppositional defiant disorder, describes genetic and environmental causes, and provides strategies for ensuring the safety of other students. The final section defines conduct disorder, along with genetic and environmental causes. Each section explains medical and clinical treatment options and provides strategies that teachers can use to support the education and treatment of students with the specific disorder, along with a list of annotated resources. (Each section contains references.) (CR)

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This document is intended for:

Students	
Teachers	✓
Administrators	✓
Counsellors	✓
Parents	
General Public	

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  - Learning Disabilities Association of Alberta
  - Premier's Council on the Status of Persons with Disabilities
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INTRODUCTION

School personnel, parents and others are increasingly concerned about students who display severe problem behaviours in schools. These behaviours can interfere with these students' ability to be academically successful, develop favourable self-concepts or enjoy positive relationships with others. These behaviours also disrupt the learning of others in the classroom. Sometimes, these abnormal behaviours are caused by emotional disorders or mental illnesses.

Teaching Students with Emotional Disorders and/or Mental Illnesses was developed through the formation of effective partnerships to improve service to students: Alberta Learning in collaboration with the Alberta Mental Health Board, the Alberta Teachers' Association and Edmonton Public Schools. It is also a project of the Alberta Children's Initiative and the Western Canadian Protocol (WCP).

The first draft of the resource was reviewed by teachers, guidance counsellors, mental health professionals and regional health authority staff from across Alberta and representatives of the Western Canadian Protocol. The resource was revised according to the feedback received and edited by the Alberta Mental Health Board to ensure technical accuracy of terminology and information.

As knowledge has increased, it has become possible for healthcare practitioners to more accurately diagnose emotional disorders or mental illnesses which have an onset in early childhood or appear for the first time in adolescence. For example, depression and schizophrenia can now be diagnosed in childhood, where previously they were considered adult disorders. Healthcare practitioners have identified emerging emotional disorders which affect both children and adolescents, such as anorexia and anxiety.

There are implications for regular and special education classrooms. Students with emotional disorders or mental illnesses are at greater risk of performing poorly in school, dropping out of

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school, socially withdrawing and attempting or committing suicide. Students with these disorders have troublesome symptoms and behaviours, not only during the school years but sometimes continuing into adulthood. Early diagnosis and treatment can significantly improve outcomes for people with these disorders.

The information included in this resource on medical and clinical treatments of these disorders is intended only to raise the awareness of educational personnel and make them more knowledgeable about therapies that students with emotional disorders or mental illnesses may receive outside school.

Specialized healthcare practitioners diagnose these disorders and determine the best methods of clinical treatment. Teachers and school counsellors can play a critical role in assisting with both identification and classroom intervention.

Teachers:

- can identify, often at an early stage, students who are at risk
- are knowledgeable about behaviours which are likely to contribute to, or interfere with, success at school
- are able to share information with students' parents, which may result in early identification of signs and symptoms
- can provide critical information to parents and healthcare practitioners about students' response to treatment
- can be major contributors to students' success
- can establish reasonable expectations
- can advocate for students with emotional disorders or mental illnesses.

Keeping anecdotal records is another way teachers can assist. Maintaining anecdotal notes of student interactions in the classroom or on the playground; changes in student behaviour, mood or attitude; and verbal, emotional or physical outbursts, provides additional, supportive information for parents and healthcare professionals making the diagnosis and providing appropriate therapy. Analyzing anecdotal notes sometimes helps determine whether the student's actions or disruptions are common or out of the ordinary for their age group, are isolated or increasing in number, are random or follow some pattern, or are triggered by particular situations.

In making anecdotal notes, teachers and other educational personnel working with the student should consider the following.

- Objectively describe the behaviour, situation or action and refrain from including value judgements or preconceived conclusions. For example, "Suzie used her hands and feet to tip over tables and chairs," rather than, "Suzie threw a temper tantrum wildly flinging table and chairs over;" or, "Johnny put his head on his desk, covered it with both hands and cried audibly for five minutes after being asked to turn in his math assignment," rather than, "I think Johnny used excessive theatrical sobbing to hide the fact that he had not completed his math assignment again."
- Record the date, time and location where the observation is made or the incident occurs.
- Include the names of any other individuals involved.
- Make the anecdotal note as soon as possible after the event occurs or the observation is made.

COLLABORATION AND DOCUMENTATION

For all students, achievement and school success are strongly affected, either positively or negatively, by the relationship between the school and home. An effective, collaborative home-school relationship provides consistency and support for students dealing with difficult and challenging circumstances. This interdependent relationship is critical for students dealing with emotional disorders or mental illnesses.

To strengthen and support this relationship, teachers and other school personnel involved in providing services to students should:

- include parents as partners in their children's education
- communicate with parents openly and frequently, both formally and informally
- treat parents with respect and dignity
- acknowledge and accept the decisions parents make regarding their children's diagnoses and treatment as reflective of their best intentions for their children
- where possible, establish consistent routines and expectations for students which work both at home and at school
- ensure that parents have information regarding school and district-level support services available for their children
- share information with parents regarding their children's progress, achievements and difficulties
- together with parents, set realistic and achievable goals and timelines for students

- include the student; especially older students where appropriate, in the planning process.

Students with emotional disorders and/or mental illnesses and their families are often involved with healthcare practitioners and other community agencies. The educational growth of students is best achieved and supported through the cooperative efforts of all individuals involved. Using a team approach to developing an individualized program plan (IPP) ensures that all critical areas of need are addressed.

An IPP should be developed when the teacher's regular instructional strategies or behavioural guidelines and their variations are not effective in helping students achieve and function at an age or grade-appropriate level. While there is no single format for developing or writing an IPP, there is consistency in the essential information to be included in an effective IPP.

IPPs are intended to be written but flexible working documents which identify:

- assessed level of educational performance
- strengths and areas of need
- long-term goals and short-term objectives
- assessment procedures for short-term objectives
- special education and related services to be provided
- review dates, results and recommendations
- relevant medical information
- required classroom accommodations (any changes to instructional strategies, assessment procedures, materials, resources, facilities or equipment)
- transition plans.

The IPP team members will vary for each student depending on the particular disorder and its severity. In addition to the classroom teacher, the team may include:

- the student, if appropriate
- parents, foster parents, guardians, caregivers or group home representatives
- psychologist
- family physician, pediatrician or psychiatrist
- mental health professional
- social worker
- probation officer
- advocate

- physiotherapist
- speech-language pathologist
- occupational therapist
- public health nurse
- school administrator
- program aides
- school counsellor
- core subject teachers
- resource teacher
- school resource officer
- consultant.

Detailed information regarding the essential information to be included in an IPP, the process for developing an IPP, samples and formats are available in *Individualized Program Plans*, Book 3 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education.

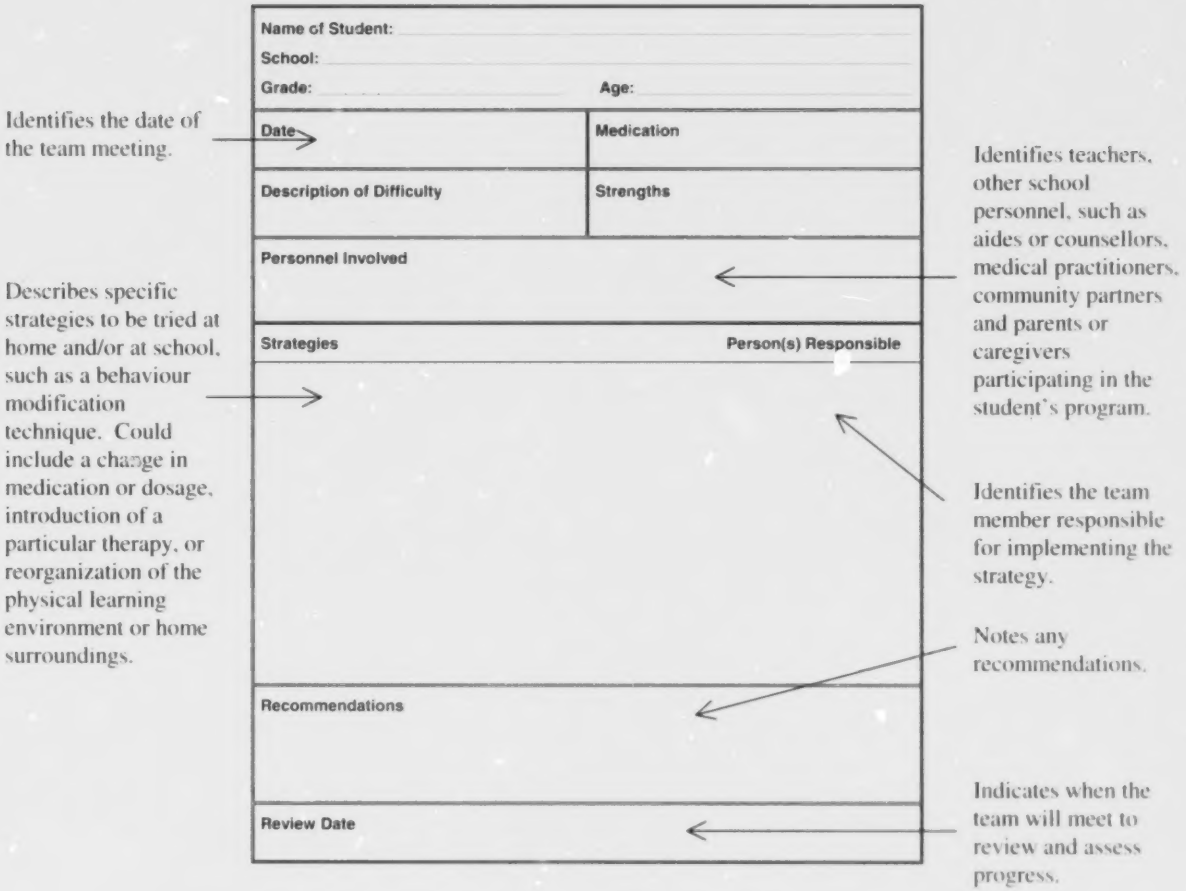
It is critical for school personnel, family members, healthcare practitioners and community advocates to work together to provide support and the best possible learning environment for all students.

This team can support one another by:

- developing trust and understanding about the role each member plays
- sharing current information regarding disorders, medication, side effects and patterns of behaviour
- establishing common routines and practices, and consistent expectations for the home, school and community.

The following form may be used by the team to document and review the strategies being implemented.

Tracking Form


Name of Student:
School:
Grade:
Age:
Date
Medication
Description of Difficulty
Strengths
Personnel Involved
Strategies
Person(s) Responsible
Recommendations
Review Date
Identifies the date of the team meeting.
Describes specific strategies to be tried at home and/or at school, such as a behaviour modification technique. Could include a change in medication or dosage, introduction of a particular therapy, or reorganization of the physical learning environment or home surroundings.
Identifies teachers, other school personnel, such as aides or counsellors, medical practitioners, community partners and parents or caregivers participating in the student's program.
Identifies the team member responsible for implementing the strategy.
Notes any recommendations.
Indicates when the team will meet to review and assess progress.

(A reproducible blank master can be found at the end of this section on page 12.)

THOUGHTS OF DEATH AND SUICIDE

In each of the disorders covered in this resource, thoughts of death or suicide may be evident as part of the emerging pattern of symptoms or as a consequence of the illness. While suicide is rare in children under 12, it does occur. The incidence of suicide fatality rises significantly in adolescence, with young people ages 15–24 most at risk.

Thoughts of death may indicate a risk of suicide and are best dealt with through an evaluation by a trained school counsellor or other mental health professional. When talking to a student believed to be at risk of suicide, they should try to determine if the student has an actual plan, the specifics of it and if the student has the means to carry out the plan.

The following factors should be considered when assessing a student's risk of suicide.[1]

Symptoms — A high-risk student may display one of more of the following symptoms:

- depression or other mental illnesses or social-emotional disorders
- sudden changes in behaviour; e.g., from being enthusiastic to being indifferent
- risk behaviours — substance abuse, sexual promiscuity, aggressiveness, self-mutilation, quitting school, leaving home, gambling, erratic driving, etc.
- preoccupation with death in writing, conversation or music; direct or indirect references to suicide
- making final arrangements; e.g., giving away prized possessions.

Stressors — The following stressors may indicate high risk:

- a significant loss or traumatic event; e.g., death of someone close, parents' separation or divorce, end of a close relationship, job loss, moving
- dysfunctional family patterns
- undue pressures; e.g., athletic and/or academic achievement, too many responsibilities.

The student's perception of the situation may be more significant than the actual event or circumstance. The more hopeless and insurmountable the situation appears to the student, the higher the risk.

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[1] From *Suicide prevention and intervention*, by Saskatchewan Education and Training, 2000, Regina, SK: Saskatchewan Education and Training.

Resources — does the student have a number of close, trusted friends, family or community members to go to for support? The fewer trusted and accessible supports, the higher the risk of suicide.

Past Attempts — talk to the student about the "when, why and how" of any past suicide attempts. A person who has attempted suicide is at higher risk for subsequent attempts.

Current State — determine the student's current mental and physical condition through observed or reported sudden changes in behaviour, attitude, personality and verbal expressions. A high-risk student may be agitated or irrational, expressing extreme despair and hopelessness. Conversely, a student who has decided to end his or her life may appear calm, relieved and even happy after a period of noticeable distress.

School personnel at all levels are encouraged to address the following components of an effective suicide prevention program:

- **staff education** to provide general knowledge about suicide, including signs, symptoms, high-risk behaviours and available community resources
- **in-school policies and procedures** for responding to at-risk students, suicide attempts and death by suicide
- **student education** to provide general knowledge about suicide and its signs, how to identify and assist at-risk peers, effective decision-making and coping strategies, and available community resources.

PURPOSE AND OVERVIEW OF THE RESOURCE

Teaching Students with Emotional Disorders and/or Mental Illnesses was written in response to a need identified by educators and other school personnel for a concise, comprehensive, knowledge-based resource manual. The conceptual framework relies on the conscious understanding of the student as an individual with problems that are unique.

The resource takes a comprehensive look at six emotional disorders: eating disorders, anxiety disorders, depression, schizophrenia, oppositional defiant disorder and conduct disorder. Each section contains definitions, medical and clinical treatments, classroom strategies for supporting students with these disorders and an annotated list of resources.

In reading the overview of the disorders, the individual sections and when working with students with emotional disorders and/or mental illnesses, it is important to remember that each student is a unique individual. Educators use terms such as "learning disability" or "behaviour disorder" and healthcare practitioners use terms such as "anorexic" or "schizophrenic," when making learning and medical diagnoses. The intent of the label is to describe with a single term a commonly accepted set of characteristics, symptoms and behaviours generally associated with the disorder. Not all individuals with the same disorder exhibit the same characteristics. Each individual with an emotional disorder and/or mental illness may exhibit few or many of the characteristics, in varying degrees of severity and frequency which may change with time and age. It is important to regard the student as a whole and complex individual with strengths and particular needs rather than focusing on the characteristics associated with the label. While labels assist in describing learning and emotional disorders, children are much more than their diagnostic label.

Descriptors for the diagnoses of the disorders included in this resource have been drawn from the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition) (DSM-IV). The DSM-IV was chosen because it is the most widely accepted and credible classification system for categorizing mental disorders.

The resource manual is not to be used for making diagnoses but is intended as a guide to assist teachers in the identification and education of students with emotional disorders and/or mental illnesses. As such, an attempt has been made to provide significant information without replicating the DSM-IV criteria in their entirety. The reader should refer directly to the DSM-IV for more comprehensive information.

The following is a brief overview of each of the sections.

Eating Disorders

This section provides definitions for three main eating disorders: anorexia nervosa, bulimia nervosa and binge eating. It describes the characteristics and symptoms of these types of disorders as well as the cycle of self-abuse. It identifies risk factors that may trigger the onset of the disorder. Myths surrounding food, weight and body image are included. It summarizes current medical and clinical treatments, and presents strategies teachers can use to assist students with eating disorders. The section also provides a list of annotated resource for teachers, students and families.

Anxiety Disorders

This section presents short descriptions of seven common anxiety disorders, including separation anxiety disorder, overanxious disorder of childhood, post-traumatic stress, acute stress, obsessive compulsive disorder, anxiety disorder due to general medical conditions and substance-induced anxiety. It also discusses specific and social phobias. The section lists common triggers, and medical and clinical treatments. It outlines strategies teachers can use to support the education and treatment of students with anxiety disorders. It also provides a list of annotated resources.

Depression

This section describes different types of depression in childhood and adolescence. It identifies common triggers and lists characteristics, such as avoidance of others and feelings of guilt. It outlines current medical and clinical treatments, and health practices that help manage depression. It includes guidelines for talking with parents and strategies for supporting students with depression. An annotated list of resources for teachers, students and families is also included.

Schizophrenia

This section presents an overview of the characteristics and causes of this uncommon mental illness. It discusses the challenges family members and school personnel face. It describes medical and clinical treatments, and outlines strategies for teaching and supporting students with schizophrenia.

Oppositional Defiant Disorder

This section defines oppositional defiant disorder and compares it with conduct disorder, which is more severe. It describes genetic and environmental causes, and medical and clinical treatment options. This section emphasizes the importance of teamwork, and

offers strategies for developing individualized program plans (IPPs) and behaviour plans. It provides strategies for working with parents and structuring successful classroom experiences for students with this emotional disorder. Strategies for ensuring the safety of other students are discussed and an annotated bibliography of teaching resources is included.

Conduct Disorder

This section defines conduct disorder and compares it to oppositional defiant disorder. The section takes the same format as oppositional defiant disorder, and describes genetic and environmental causes, and medical and clinical treatment options. The importance of teamwork is emphasized, and strategies for developing individualized program plans (IPPs) and behaviour plans are included. This section also offers strategies for working with parents and structuring successful classroom experiences for students with this type of emotional disorder. Strategies for ensuring the safety of other students are discussed and an annotated bibliography of teaching resources is included.

Tracking Form

Name of Student: _____ **School:** _____ **Grade:** _____ **Age:** _____	
Date	**Medication**
Description of Difficulty	**Strengths**
Personnel Involved	
Strategies	**Person(s) Responsible**
Recommendations	
Review Date	

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EATING DISORDERS

Eating disorders are illnesses that develop as a result of complex biological, psychological and social factors. They are often a symptom of unresolved problems perceived to be too difficult or painful to address directly. All eating disorders are characterized by severe disturbances in eating behaviours.

While most prevalent among girls and women, boys and men experience eating disorders too. It appears that the number of males with eating disorders is increasing, but this may be because more males are coming forward for treatment.

The three most common eating disorders are:

- Anorexia Nervosa — while literally meaning the "nervous loss of appetite," it is the refusal to maintain a minimally normal body weight, weighing less than 85 per cent of what is normal for height and age.
- Bulimia Nervosa — repeated episodes of binge eating (20,000 calories in an episode) followed by purging behaviours — self-induced vomiting; misuse of laxatives, diuretics, enemas or other medications; fasting or excessive exercise to prevent weight gain. Research indicates that this disorder is increasing in prevalence at a higher rate than anorexia.
- Binge or Compulsive Eating — eating large amounts of food in a short period of time leading to weight gain, obesity and a perceived lack of control over eating. Compensatory behaviours, such as purging or compulsive over-exercising, are most often absent.

The age of onset for each of these disorders is typically mid to late adolescence into early adulthood. However, indicators of eating disturbances, such as a preoccupation with weight, body size and dieting, are being found in younger students.

CHARACTERISTICS

The following characteristics or signs and symptoms of each disorder are taken in part from the diagnostic manual of the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition) (DSM-IV).[1] The DSM-IV criteria for eating disorders are included to help teachers recognize the symptoms but not for diagnostic purposes. As with other complex mental health problems, diagnosis and treatment is best left with mental health professionals and physicians.

Anorexia Nervosa

The DSM-IV criteria for diagnosis include:

- refusal to maintain body weight over a minimal normal weight for height and age
- intense fear of gaining weight or becoming fat, even though the individual is underweight
- disturbance in the way in which one's body weight, size and shape is experienced — the person feels fat and claims to see oneself as fat even when emaciated.

Bulimia Nervosa

The DSM-IV criteria for diagnosis include:

- repeated episodes of binge eating, occurring at least twice weekly for three months, and characterized by:
  - eating in a given time period a much larger amount of food than most people would eat during a similar time period and under similar circumstances
  - an awareness of lack of control over eating during the binge and a feeling that one can't stop eating or control the amount of food being consumed
- repeated inappropriate behaviours to prevent weight gain, (referred to as "compensatory" behaviours) such as self-induced vomiting; misuse of diuretics, enemas and other medications; fasting and compulsive exercise
- one's self-perception and self-esteem significantly influenced by personal body shape and weight.

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[1] From *Diagnostic and statistical manual of mental disorders* (4th edition) (pp. 544–545, 549–550), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

Binge or Compulsive Eating Disorder

While the DSM-IV does not include specific diagnostic criteria, the following list of characteristics was presented in a draft document of the University Health Centre, University of Alberta.[2] The absence of compensatory behaviours differentiates binge or compulsive eating disorder from bulimia.

The characteristics are:

- repeated episodes of binge eating, occurring at least twice weekly for six months, and characterized by:
  - eating in a given time period a much larger amount of food than most people would eat during a similar time period and under similar circumstances
  - an awareness of lack of control over eating during the binge and a feeling that one can't stop eating or control the amount of food being consumed
- during binge episodes, at least three of the following are present:
  - eating faster than usual
  - eating until uncomfortably full
  - eating large amounts of food when not physically hungry
  - eating large amounts of food throughout the day with no planned meal times
  - eating alone because of being embarrassed by how much one is eating
  - feeling disgusted with oneself, depressed or guilty after bingeing
- absence of compensatory behaviours so weight gain is more likely.

The following chart lists signs and symptoms that might be observed in students by teachers, and/or reported by the student, classmates, parents and other family members.[3]

---

[2] From *Food, weight and body image: achieving a healthy balance — background information* (draft) (p. 4). University Health Centre, July 17, 1995, Edmonton, AB: University Health Centre, University of Alberta. Reprinted with permission.

[3] Adapted from *Eating and exercise disorders* (pp. 1–3), by J. B. Rubel, 1992, Eugene, OR: Anorexia Nervosa and Related Eating Disorders, Inc. Used with permission of ANRED: Anorexia Nervosa and Related Easting Disorders, Inc. http://www.anred.com.

Signs and Symptoms of Eating Disorders

	Anorexia Nervosa	Bulimia Nervosa	Binge or Compulsive Eating Disorder
Behaviours What a teacher might observe or what might be reported by a student with an eating disorder or peer, or parent.	– refuses to eat except for small amounts of a few "safe" foods – diets even when underweight – shops for groceries and cooks for others, but won't eat – obsesses about meal plans, keeps calorie journals – compulsively weighs and measures food – hoards and hides food in locker or knapsack – combines foods and condiments strangely – exercises compulsively – hides body under layers of loose-fitting clothing – withdraws from relationships, becomes socially isolated – insists he or she is fat, even when alarmingly thin – denies anything is wrong, becomes sullen, angry or defensive when concern is expressed	– eats large amounts of food quickly – secretively gobbles "forbidden goodies" – prefers high-fat, high-sugar binge foods – tries to undo binges by vomiting, exercising, fasting or abusing laxatives and diuretics – may shoplift, binge spend, abuse alcohol, use street drugs or become sexually promiscuous – leaves school early in the day – increased school absences	– binge eats in times of stress, excitement or loss – nibbles and snacks over several hours – may or may not overeat at mealtime – usually doesn't overeat in front of others – prefers high-sugar, high-fat comfort foods – diets, becomes hungry, overeats and feels out of control – eats to relieve stress and numb painful feelings
Statements What a teacher might hear directly from the student when exploring concerns, or indirectly in student interactions with peers.	– "I'm too fat. I'll be happier when I'm thinner." – "Being thin is the most important thing in the world." – "I'm not hungry. I'm fine. I'm in control."	– "I want to stop bingeing and purging, but I'm afraid I'll gain weight if I do." – "When I start to eat, I don't think I can ever stop." – "I want people to like me, but I'm afraid when they get too close."	– "I'm lonely. I'll eat. Food is love." – "I'm stressed. I'll eat. Food is comfort." – "I did good today. I'll eat. Food is a reward." – "Something is wrong with me. I have no willpower." – "I have no control. I'm bad. I'm a failure."

Signs and Symptoms of Eating Disorders (cont'd)

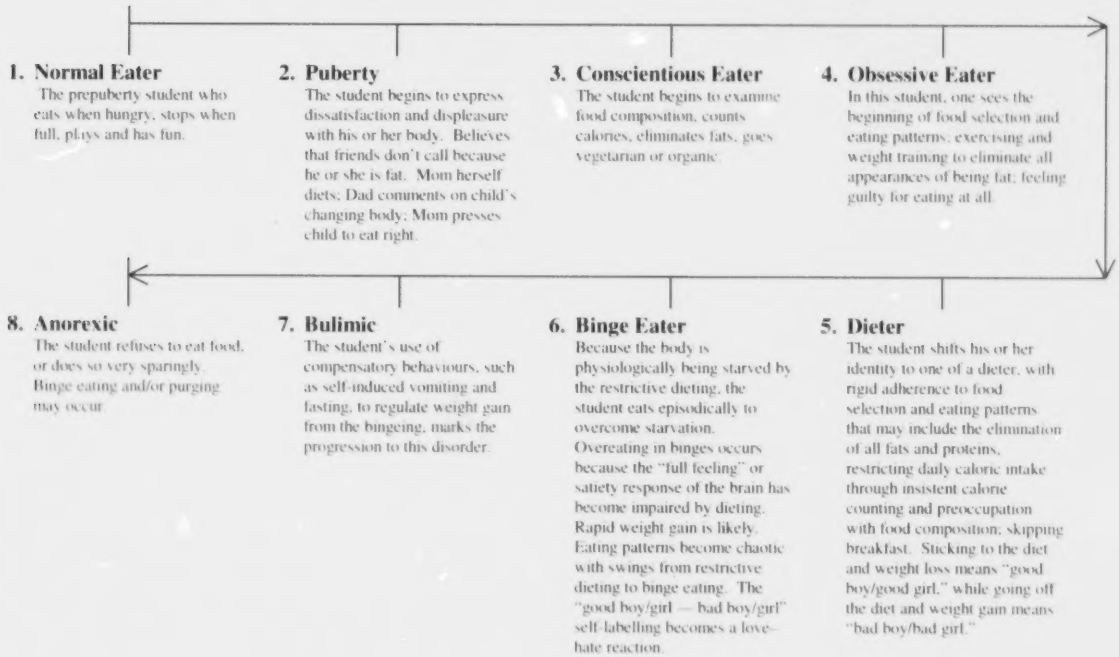
	Anorexia Nervosa	Bulimia Nervosa	Binge or Compulsive Eating Disorder
Feelings What a teacher might observe from student interactions, and have confirmed in exploring concerns with the student.	– is inadequate, anxious, worthless, depressed, desperate – is angry, irritable, sullen, resentful, defiant, stubborn – is sad, lonely, deprived – has low self-esteem, may be suicidal – constantly fears weight gain that may mask all the above	– is out of control while bingeing – is embarrassed, guilty, ashamed, has low self-esteem – is depressed, desperate, sometimes suicidal – is afraid of discovery – is lonely — wants friends and relationships, but fears closeness with others	– is embarrassed, guilty, ashamed, has low self-esteem – is depressed, sometimes suicidal – may fear closeness with others
Physical Symptoms What a teacher might observe or be reported by a peer or parent.	– is hungry, has cravings, is preoccupied with food, and in many cases, binge eats – has dry, scaly skin that may be yellow or gray in colour – has dull, brittle, thin hair – looks like a skeleton — no muscle or fat – has loss of menstrual periods – has icy hands and feet, is cold when others are warm – has downy fuzz on face, limbs and body – has loss of bone minerals, proneness to fractures – is constipated, has digestive discomfort, abdominal bloating – is dehydrated, has muscle cramps, tremors – has dental problems	– weight fluctuates because of alternating diets and binges – has swollen glands in neck under jaw – loses tooth enamel, has broken blood vessels in face and eyes, has bags under eyes caused by vomiting – is dehydrated, has fainting spells, tremors and blurred vision – has laxative dependency, damage to bowels – has indigestion, cramps, abdominal discomfort, bloating, gas, constipation – has suicidal depression	– gains weight, is sometimes obese – has increased risk of bone and joint problems with a proneness to fractures

CYCLE OF SELF-ABUSE

What triggers the onset of eating disorders depends on both the disorder and the particular student. With anorexia, it may be a stressful life event, like changing schools or the divorce of parents. An initial bulimic episode may occur during or after restrictive dieting, when the student feels deprived. Binge eating often becomes a habitual way of responding to stress and feelings of loneliness and disappointment, or of giving oneself gratification.

Some experts suggest that eating behaviours may move along a continuum of severity, from normal eating to the actual onset of bulimia or anorexia. However, one does not have to progress through all or any eating styles prior to developing an eating disorder. For example, the onset of puberty alone with its resulting body changes, can trigger an eating disorder, particularly if there are other intervening risk factors. (See the following section for a description of risk factors.) The following graphic illustrates this continuum.[4]

An Eating Behaviours Continuum of Severity[4]


1. Normal Eater
The prepuberty student who eats when hungry, stops when full, plays and has fun.
2. Puberty
The student begins to express dissatisfaction and displeasure with his or her body. Believes that friends don't call because he or she is fat. Mom herself diets; Dad comments on child's changing body; Mom presses child to eat right.
3. Conscientious Eater
The student begins to examine food composition, counts calories, eliminates fats, goes vegetarian or organic.
4. Obsessive Eater
In this student, one sees the beginning of food selection and eating patterns; exercising and weight training to eliminate all appearances of being fat; feeling guilty for eating at all.
5. Dieter
The student shifts his or her identity to one of a dieter, with rigid adherence to food selection and eating patterns that may include the elimination of all fats and proteins, restricting daily caloric intake through insistent calorie counting and preoccupation with food composition; skipping breakfast. Sticking to the diet and weight loss means "good boy/good girl," while going off the diet and weight gain means "bad boy/bad girl."
6. Binge Eater
Because the body is physiologically being starved by the restrictive dieting, the student eats episodically to overcome starvation. Overeating in binges occurs because the "full feeling" or satiety response of the brain has become impaired by dieting. Rapid weight gain is likely. Eating patterns become chaotic with swings from restrictive dieting to binge eating. The "good boy/girl — bad boy/girl" self-labelling becomes a love–hate reaction.
7. Bulimic
The student's use of compensatory behaviours, such as self-induced vomiting and fasting, to regulate weight gain from the bingeing, marks the progression to this disorder.
8. Anorexic
The student refuses to eat food, or does so very sparingly. Binge eating and/or purging may occur.

[4] Adapted from "Eating disorders: a continuum," by J. Marchuk, M.Ed. C.Psych., notes from a presentation to the Alberta Teachers' Association Guidance Specialist Council, Annual Conference, Banff, Alberta, November 6–8, 1997. Adapted and used with the permission of J. Marchuk.

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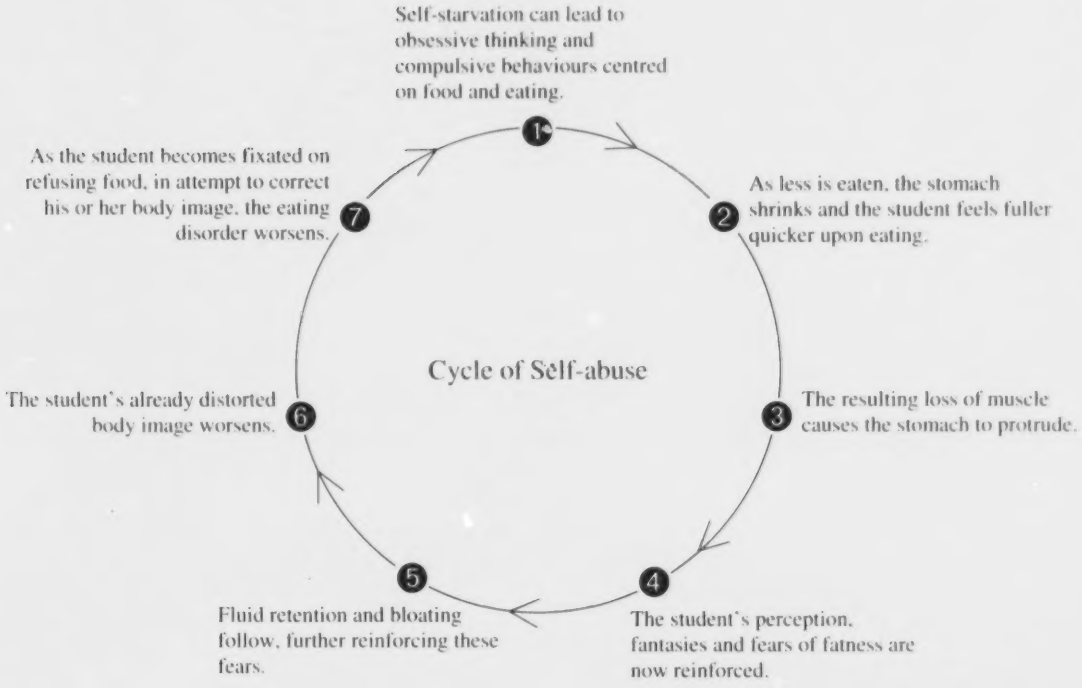
The potential for escalation into a cycle of self-abuse is common with each disorder because of the resulting effects on the student's perception, thinking, mood and behaviour. This is illustrated in the following continuum.


Self-starvation can lead to obsessive thinking and compulsive behaviours centred on food and eating.
1
As less is eaten, the stomach shrinks and the student feels fuller quicker upon eating.
2
The resulting loss of muscle causes the stomach to protrude.
3
The student's perception, fantasies and fears of fatness are now reinforced.
4
Fluid retention and bloating follow, further reinforcing these fears.
5
The student's already distorted body image worsens.
6
As the student becomes fixated on refusing food, in attempt to correct his or her body image, the eating disorder worsens.
7
Cycle of Self-abuse

RISK FACTORS

Eating disorders are best viewed as complex illnesses which reflect an interplay among several risk factors. Risk factors are those events, dynamics, traits, thoughts, attitudes and behaviours that contribute to the development of a disorder. Typically, the greater the number of risk factors, the greater the chance of developing an eating disorder. However, the development of eating disorders is a complex process subject to great differences among students. The following risk factors are those agreed upon by researchers and helping professionals as being significant in the development of eating disorders.

Culture

Eating disorders are most prevalent in industrialized, developed countries where there is an abundance of food. In these countries, there are often cultural standards and ideals for people to have youthful, slim, muscular, well-defined bodies. Media, through movies, television, magazines and advertising portray these standards and ideal images as leading to heightened self-worth, confidence, popularity, love, beauty, success and happiness. This is compounded by conflicting cultural expectations and roles, especially for females.

Family

Because of the highly individualized picture that emerges in the student who develops an eating disorder, research is inconclusive in determining the specific contributing family dynamics. These dynamics may include unresolved issues, patterns of interacting among members, attitudes, behaviours and rules. Care must be taken to avoid blaming parents and family members when a student develops an eating disorder. The following is a list of commonly seen family risk factors:

- parents' ideals of success, perfectionism and high achievement
- family relationships that may be perceived as intrusive, over-protective and controlling
- family attitudes and perceptions that have difficulty tolerating differences, and that encompass a "right/wrong, black/white" way of looking at the world
- family avoidance of conflict
- family preoccupation with food, dieting, appearance and physical fitness so that the child feels pressure to conform or rebel
- family coping behaviours that may include parental alcoholism or other chemical dependency
- family history of sexual abuse, eating disorders or affective disorders, such as depression or anxiety.

Personal Situation

Eating disorders are most prevalent among adolescent and young adult females who have a distorted body image, are preoccupied with weight and dieting, and who use this preoccupation to defend against other painful unresolved issues. Regardless of gender, students may be slightly overweight at the onset of the disorder and many have used previous fasting episodes as a way to lose or maintain weight.

Other personal risk factors applicable to female or male students include:

- low self-esteem and feelings of inadequacy which are temporarily alleviated by the success one feels with losing weight
- perfectionism — the need to be the best in everything they do and are self-critical when they fail to meet their standards
- strong need to be liked by peers and adults
- issues of separation from parents, including doubts about one's identity, values, beliefs, likes and dislikes
- perceptual disturbances involving the body — thinking that they look fat, feeling full after a snack or small meal
- high need for control and predictable structure — unexpected changes in routine can lead to anger and fear.

Biology

Research is inconclusive as to the biological factors of eating disorders. Medical studies of twin children indicate that a genetic factor leads to the development of anorexia. Anorexia has also been shown to be associated with brain disturbances as evidenced by electroencephalograms. Hormone fluctuations affecting the hypothalamus, the part of the brain that contains the feeding and satiety or fullness centres, may contribute to eating disorders. There is also speculation that pre-existing depression or an obsessive-compulsive disorder may contribute to the onset of bulimia.

Myths About Food, Weight and Body Image

Many people have ideas about food, weight and body image that have little basis in scientific fact, but are more indicative of learned attitudes. These myths, if unchallenged, can lead to inaccurate perceptions and unhealthy behaviours. Several myths commonly held by students, and even adults follow.

Being slim will help me become popular, successful and happy. Advertising contributes to this faulty notion of success and happiness. In fact, the obsessive nature of eating disorders, coupled with feelings of shame and the drive to perfectionism can result in withdrawal from friends, and little time to feel happy or pursue activities that would bring feelings of pleasure and success.

Being female means I was born to diet. Many female students report significant exposure to dieting and concern with body image and size by other female family members — mothers, aunts, grandmothers. Our cultural expectation for females to be attractive, slim and youthful is compounded by the media and advertising focus on females for dieting, fashion, exercise, and food products and services. However, males preoccupied with body shape and weight can develop disordered eating patterns as well as shape-control practices, such as steroid use.

Anybody can be slim — it takes self-control. One's body weight is resistant to change, being tied to metabolism, body type and other factors. It seems that each body has a set point weight where it naturally stays. Dieting moves this upward in response to the calorie deprivation that the body experiences as threat of starvation.

MEDICAL AND CLINICAL TREATMENTS

The diagnosis of eating disorders should only be made by qualified mental health professionals. Teachers can assist by maintaining accurate records and anecdotal notes regarding observations, student interactions, and evidence of student growth, achievement and behaviour. The information included in this resource on medical and clinical treatments of these disorders is intended only to raise the awareness of educational personnel and make them more knowledgeable about therapies that students with emotional disorders or mental illnesses may receive outside school. All medical and clinical therapies must be administered and monitored by qualified mental health professionals.

Because of the number and complexity of risk factors contributing to the onset and development of eating disorders, treatment is challenging and must encompass a multi-model approach.[5]

Depending on severity, the first treatment goal is stabilizing the physical condition through medical interventions, including medication, nutrition management and possible hospitalization. With restoration to a stable nutritional state, the second treatment

[5] From "Anorexia nervosa: diagnosis and management, part II," by M. Blackman & T. Pucci, 1996, *Canadian Journal of Clinical Medicine*, August, p. 18. Reprinted with permission.

goal is normalizing eating habits. The third treatment objective is changing the distorted thinking patterns about body image, and beginning therapy to address the underlying emotional and psychological factors.[6]

Hospitalization

In severe cases of anorexia and bulimia, with their resulting chronic starvation, dehydration, electrolyte and hormonal imbalances, direct intervention via hospitalization or admission to a specialized treatment facility may be necessary to prevent death, as a direct consequence of starvation, or due to suicidal risk.

Medications

Medications are sometimes used to relieve the depression or anxiety underlying eating disorders. They are cited as having little direct effect on the primary condition and should never be used as the only means of treatment for eating disorders.[7] The student may be reluctant to take medications because of side effects (Yager et al., 1992), which often include weight gain, and the resultant fears of loss of control over eating patterns, weight and body changes (Szmukler et al., 1995). Medication use must be closely supervised by a physician to ensure compliance and prevent misuse.

Nutritional Therapy

A dietician, working in a team approach with other health care professionals, will help the student and family develop food plans and eating patterns that are supportive of health. By observing the student's eating patterns and compiling a dietary history, including the student's eating patterns, weight control methods, forbidden foods and reasons for the behaviours, the dietician can help the student adopt a relaxed eating pattern and provide correct nutritional information to the student and family.[8]

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[6] From "Anorexia nervosa: diagnosis and management, part II," by M. Blackman & T. Pucci, 1996, *Canadian Journal of Clinical Medicine*, August, p. 18. Reprinted with permission.

[7] Ibid., p. 19.

[8] Ibid., p. 20.

Dental Care

Teeth may be damaged by chronic patterns of starvation and vomiting (as stomach acid destroys dental enamel). A dentist may need to repair dental damage, thereby enhancing the student's body image.

Psychotherapy

Because eating disorders develop as a result of underlying emotional and psychological issues, psychotherapy is a significant component of the overall treatment program, occurring once there is sufficient physical stabilization with a return to normal body weight, and relief from the delusional, depressive and/or compulsive symptoms. Typically three forms of therapy are encouraged, often happening simultaneously.

- **Individual Therapy** — This therapy is aimed at helping the individual with an eating disorder understand the internal conflicts and belief systems leading to the development of an eating disorder.

- **Group Therapy** — Working with others with similar conditions is therapeutic in restoring hope for recovery, building satisfying relationships, getting feedback from others on dysfunctional belief systems, and learning effective ways to live a healthy life.

- **Family Therapy** — Eating disorders affect the entire family, not only the individual. Family therapy, working with all members of the student's immediate and sometimes extended family (if they are involved) seeks to improve family interactions and relationships. It helps the family find new and effective methods of dealing with the eating disorder, while promoting an environment conducive to the healthy development of all members.[9]

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[9] From "Anorexia nervosa: diagnosis and management, part II," by M. Blackman & T. Pucci, 1996, *Canadian Journal of Clinical Medicine*, August, p. 19. Reprinted with permission.

SCHOOL STRATEGIES TO ASSIST STUDENTS WITH EATING DISORDERS

There are a number of specific strategies and resources available to help schools respond to students whose behaviour is causing concern. Efforts should be aimed at the prevention of the occurrence of an eating disorder (primary prevention) or the identification and correction of a disorder in its earliest stages (secondary prevention). The basic principles for the primary prevention of eating disorders follow.[10]

- Because eating disorders are serious and complex, and are often symptoms of unresolved problems, they should never be seen as simply a plea for attention.
- This is not just a girls' problem. Prevention should be aimed at both genders, as males concerned with body shape and weight may develop eating disorders too.
- Prevention efforts will fail, or worse, inadvertently encourage disordered eating if they concentrate only on warning about the signs, symptoms and dangers of eating disorders.
- Prevention strategies must address cultural factors, such as the obsession with slenderness and society's distorted view of femininity and masculinity.
- Prevention strategies must also focus on the development of self-esteem and self-respect.
- School prevention programs should include opportunities for students to speak confidentially with a teacher or counsellor and receive referrals to sources of competent, specialized care, such as family physicians, counsellors or nutritionists.

The Eating Disorders Awareness and Prevention (EDAP) group in Seattle, Washington recommends the following primary and secondary prevention strategies for schools.[11]

Primary Prevention Strategies

- Emphasize the development of student self-esteem, critical thinking, self-assertion and effective communication skills.

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[10] Adapted from "A Guide to the primary prevention of eating disorders" (brochure), by M. D. Maine & M. P. Levine, 1998, Seattle, WA: Eating Disorders Awareness and Prevention, Inc. Adapted with permission.

[11] Ibid.

- Teach, in health, physical education and science classes, the genetics of diversity in body build, weight, the brain's regulation of body weight, the role of fat deposition in physical development, the biology of hunger and satiation, and the dangers of dieting and low body fat percentage, especially in females.
- Teach the role of culture and advertising in promoting prejudice against fatness in health, physical education, science and social studies classes. Refute the myth that thinness is goodness and the belief that people, especially females, should sacrifice their health and self-respect for beauty.

Secondary Prevention Strategies

- Use professional development resources to teach staff about eating disorders and shape-control practices (steroid use).
- Develop systems and processes within schools whereby teachers and coaches can reach out and help students who express problems through their eating.
- Serve healthy meals in the school cafeteria and give students adequate time to eat.
- Provide parent education on the nutritional needs of children at various points of their development.

Teachers who suspect a student of having an eating disorder are encouraged to consider the following.

DO	
• Speak about your concerns with the student privately, selecting a time and place to talk where you won't be interrupted.[12] • Indicate to the student, in a direct and non-punitive manner, all the specific observations that have raised your concern.[12] • Listen to the student carefully, non-judgmentally and empathetically.[12] • Communicate your care, concern and desire to talk about the problem. Your responsibility is not to diagnose or counsel, but to develop a compassionate and forthright conversation that helps the student find understanding, support and the proper therapeutic resources.[12] • Tell the student, if the information you receive is compelling, that: – you sense he or she is experiencing some difficulties – you think the matter needs to be evaluated professionally – you understand that participation in sports or other activities will not be jeopardized unless health has been compromised to the point where such participation is dangerous[12] – you need to inform the student's family of your concerns.	• Avoid an argument or battle of wills. Repeat the evidence, your concern, and if warranted, your conviction that something must be done, including informing the parents.[12] • Be knowledgeable about community resources and reading materials to which the student can be referred.[12] • Conference with the student's family, health care professionals and other involved school staff to ensure that a mutually reinforcing treatment plan is in place to support the student's recovery. • Have patience, recognizing that the student's recovery is a lengthy process and that relapse may occur. • Provide only as much support as you can, seeking collegial/administrative support for yourself as needed. • Recognize that most eating disorders are less about food, weight and body size, and more about low self-esteem, a perceived lack of control, fear and other unresolved, painful issues.
DON'T	
• Comment on the student's appearance either positively or negatively, as it can perpetuate the obsession with body image. Throughout the process of detection, referral and recovery, the focus should be on the student feeling healthy and functioning effectively.[12] • Get into a power struggle with the student over food or eating as the disorder may be the student's expression of a need for control.	• Blame yourself, the family or the student for the disorder. • Intentionally or unintentionally become the student's therapist, victim or saviour. Attempts to moralize, develop treatment plans or closely monitor the student's eating are not helpful.[12] Due to its complexity, treatment is best left to qualified health professionals.

[12] Adapted from "Faculty and student guidelines for meeting with and referring students who may have eating disorders" (p. 1), by Michael P. Levine, Ph.D., Professor of Psychology, Kenyon College, Past President, Board of Trustees, Eating Disorders Awareness & Prevention, Inc. (www.edap.org), presented at the 13th National Eating Disorders Organization Conference, Columbus, OH, October 3, 1994. Adapted with the permission of Dr. Levine.

When a student requires hospitalization, consider the following strategies.[13]

- Maintain contact with the student during absences due to hospitalization or intensive outpatient treatment. Classmates may want to keep in touch by writing letters.
- Help the student make the transition back to the classroom, especially after a long absence, by maintaining open communication and meeting ahead of time to plan re-entry.
- Work with the hospital home-bound teacher or day treatment program teacher to help the student stay organized and informed about assignments and activities.

Classroom Strategies to Assist Students with Eating Disorders

If teachers are the first to identify symptoms that may indicate an eating disorder, they are advised to:

- privately and with sensitivity, raise their concerns with the student
- with the student's consent, invite the parents and student to a face-to-face meeting, at a time agreeable to everyone, to discuss their observations
- consider seeking assistance from school counsellors or social workers to prepare for the meeting, and/or have them speak at the meeting about eating disorders, to help the parents and student make the connection to the teachers' concerns
- outline the concerns, focusing on the student's observable behaviours, checking for consistency with at-home behaviours
- recommend or request a referral to the student's family physician for a qualified assessment of the concerns
- request follow-up contact with the parents after the physician's assessment to determine an effective and supportive intervention plan for school personnel.

The following classroom strategies presume that the parents of students with eating disorders are aware and involved in the treatment. When dealing with students with eating disorders, teachers are advised to develop educational programs that are integrated, interdisciplinary and individualized to ensure that the opportunity for successful recovery is enhanced.[14] In addition, teachers are encouraged to consider the following strategies.[15]

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[13] From *Awareness of chronic health conditions: what the teacher needs to know (volume 2)* (p. 4), by R. S. Manley, H. Rickson & B. Standeven, 1998, Victoria, BC: British Columbia Ministry of Education. Reprinted with permission.

[14] Ibid., p. 2.

[15] Ibid., pp. 4–5.

- Be flexible with tests and class work, as absences to attend medical and/or therapy appointments may be necessary. Flexibility also reduces students' anxiety and stress.
- Recognize that students with eating disorders may be rigid in their thinking and tend to set unrealistically high standards for their academic work. They may experience distress with respect to their schoolwork. Help them adopt a more moderate approach to schoolwork.
- It may be helpful to discourage obsessive study habits and encourage a healthy balance between peer relationships, school and extra-curricular activities.
- Establish study and homework routines in discussion with students and parents in ways that support other treatment plans.
- Use visual timelines to help students develop time-management skills and appropriate study habits.
- Recognize and understand that these students may be experiencing the effects of starvation, making concentration on schoolwork difficult, and previously understood concepts and materials incomprehensible.
- Work with and support the student in maintaining peer relationships and social activities.
- Anticipate problems before behaviour escalates. Indicators are moodiness, depression, anxiety, irritability, agitation, overreaction to minor events by withdrawal and tears.

In addition to the above recommendations for teachers dealing specifically with students suspected of or having eating disorders, the following classroom strategies can help create a preventative environment for all students.

- Create a classroom environment that celebrates diversity in body size, colour, shape; in ideas, perceptions, attitudes; and that is void of risk factors that contribute to misperceptions about health, body image and self-respect.
- Maintain zero tolerance of appearance-based jokes, taunts, insults and harassment.
- Model and build in regular opportunities for open dialogue around issues affecting students today, including, but not limited to, eating disorders.

- Use journal writing as an alternative to classroom dialogue groups.
- Spend time on a daily basis having students focus on and affirm their healthy life choices.
- Use curriculum to teach about eating disorder risk factors and challenge myths about food, weight and body image, shape and size.
- Design lessons that encourage student social action against advertising and events that perpetuate myths contributing to eating disorders, via letter writing campaigns, product boycotts, class projects and productions, such as art, drama, music. These initiatives can be cross-curricular, while teaching critical thinking, communication, self-assertion and citizenship skills.
- Have students develop lessons to teach their classmates about eating-related issues.
- Have print information, including brochures, Internet web site addresses, community resource professionals, poster displays and media samples on display for students to take and read.
- Develop peer support groups within the classroom to encourage students to talk with each other.
- Offer healthy food choices in class activities.

Because of the underlying issues, including shame, control, guilt and social isolation, it is important to consult students with eating disorders in the development of classroom strategies to assist them. Getting their input into what will be comfortable, what will support their autonomy and reduce their shame without compromising their health or any existing treatment, is essential to demonstrating support and care.

RESOURCES

This listing is not to be construed as explicit or implicit departmental approval for use of the resources listed. The writers have provided these titles as a service only, to help school authorities identify resources that contain potentially useful ideas. The responsibility to evaluate these resources prior to selection rests with the user, in accordance with any existing local policy.

Resources listed in this section can be ordered from local bookstores and/or publishers/distributors. See pages 35–37 for addresses for publishers/distributors.

Weight Preoccupation and Cultural Influences

Reviving Ophelia: saving the selves of adolescent girls (1995) by Mary Pipher. New York, NY: Ballantine Books. ISBN 0–345–39282–5. Check with your local bookstore.

This book is structured around therapy case studies of various teenage girls. The author's premise is that despite the women's movement, adolescent females are coming of age in a culture saturated with sexist media images and expectations. This hostile environment can cause girls to stifle their natural impulses and self-esteem. The book's 15 chapters cover theoretical and developmental issues of adolescence, the importance of family background, the roles of mothers and fathers, depression, societal pressures to be thin and beautiful, drug and alcohol use, sex and violence, and the differences between the world that female adolescents face today and the one their parents may have known.

Unbearable weight: feminism, western culture, and the body (1993) by Susan Bordo. Berkeley, CA: University of California Press. ISBN 0–520–08883–2 (paperback).

This academic text gives an overview of feminism, western culture and the body. It explores the myths, ideologies and pathologies of the modern female body, and society's fascination with food, hunger, desire and control. The author traces parallels between the current prevalence of eating disorders with tension within consumer society, cultural ambivalence towards female appetite and the contemporary backlash against women's power. She suggests that there is a link between the fear of women's fat and fear of women's power, and that as opportunities for women increase, their bodies dwindle.

Therapy and Self-help

Anorexia nervosa: a survival guide for families, friends and sufferers (1997) by Janet Treasure. Washington, DC: Taylor & Francis. ISBN 0–86377–760–0. Available from Irwin Publishing.

This book offers an overview of what anorexia nervosa is, cultural and genetic influences, and personal characteristics that put people at risk. It provides a historical background, including treatment trends over time. The book offers caretakers ideas for acknowledging the problem, pulling together as a family and what to do about eating. For people with anorexia, the book offers information on understanding themselves, the dangers of the disease and what they need to know about nutrition and body composition. It also examines personality patterns and phases of recovery. Advice to therapists, teachers and family doctors is also included.

The Body image workbook: an 8 step program for learning to like your looks (1997) by Thomas F. Cash. Oakland, CA: New Harbinger Publications, Inc. ISBN 1–57224–062–8 (paperback).

This self-help workbook for adults outlines eight steps to a more positive body image. It offers help sheets and information for readers to identify their own personal body image and begin to use this knowledge for change. The book offers advice for creating comfortable reflections, correcting private body talk and changing self-defeating behaviours. The last two chapters offer strategies for preserving positive body image for life. The book contains exercises, self-assessment inventories, and reflection and journal exercises that could be adapted to an adolescent population.

Feminist perspectives on eating disorders (1994) by Patricia Fallon, Melanie A. Katzman & Susan C. Wooley. New York, NY: Guilford Press. ISBN 0–89862–180–1. Available from Login Brothers Canada.

This book, targeted at health practitioners and students, reflects the psychology of women as it analyzes a range of eating disorders, and food and weight problems. The chapters cover diverse issues, including obesity, adolescence, politics, advertising and education. The authors discuss several controversial topics, including the relationship between sexual abuse and eating disorders, the use of medications, and the role of hospitalization and 12-step programs. This text examines issues in the development, perpetuation and recovery processes, and outlines strategies for prevention of eating disorders.

Resources for Children, Teens and Parents

All shapes and sizes: promoting fitness and self-esteem in your overweight child (1994) by Teresa Pitman & Miriam Kaufman. Toronto, ON: HarperCollins. ISBN 0–00–638020–4.

This book discusses how being larger than the current ideal can be a painful experience for overweight children. The authors discuss reasons why children may be overweight, and look at various truths and myths about weight. The book provides strategies for parents to help by increasing their children's overall fitness level through healthy eating and increased activity. The authors examine the link between television and weight gain, offer suggestions for coping with teasing and negative feelings, and outline ways to improve fitness for the entire family. The authors emphasize that bolstering children's self-concept goes a long way toward creating and maintaining a positive body image.

Am I fat? Helping young children accept differences in body size (1992) by Joanne Ikeda & Priscilla Naworski. Santa Cruz, CA: ETR Associates. ISBN 1–56071–080–2.

Directed to teachers, parents and other caregivers of children up to the age of 10, this book discusses the link between weight, body image and self-esteem. It encourages adults to look at their own feelings about weight, and the attitudes and behaviours they model for children. It suggests classroom activities and environmental changes that encourage children to respect the diversity of human appearance. With acceptance as the focus, six chapters analyze unrealistic expectations about body size, discuss how prejudice and discrimination are linked to weight issues, and give suggestions for handling teasing and name calling. The book also includes case studies, nutritional guidelines and healthy recipes.

Food fight: a guide to eating disorders for preteens and their parents (1997) by Janet Bode. New York, NY: Aladdin Paperbacks. ISBN 0–689–81086–5 (paperback). Available from Distican.

This book describes symptoms, causes and ways to deal with anorexia and bulimia in young girls. Part one is directed at young readers and uses first-person accounts of preteens to describe symptoms and feelings associated with eating disorders. Interviews with parents, doctors and other experts are also included. Quotes, checklists and fact boxes weave factual information with personal narratives. It offers nutritional and psychological advice, such as how to face the facts and change internal messages. Part two is addressed to parents and outlines potential triggers of eating disorders and suggestions for preventing this illness.

Just for girls: a program to help girls safely navigate the rocky road through adolescence and avoid pitfalls such as eating disorders and preoccupation with food and weight (1999) by Sandra Susan Friedman. Vancouver, BC: SALAL Books. ISBN 0–9698883–1–7.

This manual offers suggestions for facilitating an eating disorder prevention program. Using an open-discussion group format, this program encourages adolescent girls to defuse the language of fat and self-depreciation before these turn into low self-esteem, depression or disordered eating. The program looks at Canadian culture and its effect and influence on adolescent girls. The book contains structured session plans, reproducible handouts and a list of resources. Activities explore topics of food and weight, dealing with bullying, handling stress, interpreting media messages, and understanding and expressing feelings.

Publisher/Distributor Addresses

Distican
35 Fulton Way
Richmond Hill, ON L4B 2N4
Telephone: 1–800–268–3216 or (905) 764–0073
Fax: 1–888–849–8151 or (905) 764–0086

ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061–1830
U.S.A.
Telephone: 1–800–321–4407
Fax: 1–800–435–8433

Guilford Press, New York, NY U.S.A.
Canadian Distributor:
Login Brothers Canada
324 Saulteaux Crescent
Winnipeg, MB R3J 3T2
Telephone: 1–800–665–1148 or (204) 837–2987
Fax: 1–800–665–0103 or (204) 837–3116

HarperCollins Canada, Ltd.
1995 Markham Road
Scarborough, ON M1B 5M8
Telephone: (416) 321–2241
Fax: (416) 321–3033

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ANXIETY DISORDERS

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ANXIETY DISORDERS

Worry, angst, nerves and the jitters are words commonly used to describe anxiety, a normal human state of being — for children and adolescents as well. In fact, a certain amount of anxiety is necessary to live safe and effective lives. It is only when people feel overwhelmed or crippled by the intensity and duration of their anxiety that they may be said to have problem anxiety or an anxiety disorder. A person diagnosed with one anxiety disorder is likely to be diagnosed with another, and for a third of cases over a lifetime, a person diagnosed with an anxiety disorder is likely to be diagnosed with depression at some point.[1]

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) lists 14 anxiety disorders. Of these, the seven experienced by children and adolescents are highlighted in the following sections. Anxiety disorders range from mild to severe in intensity. They tend to be episodic with dramatic symptoms occurring during periods of high stress. However, even between flare-ups, individuals with anxiety disorders are less happy and less effective than they could be if they learned better coping behaviours.[2]

Problematic anxiety consists of a physiological side, involving activity in various systems:

- breathing (shallow, rapid)
- heart (pounding, skipped beats)
- vascular (blushing, fainting, dizziness)
- musculoskeletal (trembling, feelings of weakness in the limbs, aches, stiffness)
- dermatological (increased sweating, clammy skin)
- digestive (stomach ache, nausea, vomiting, diarrhea).[3]

It also consists of a psychological side:

- apprehensive self-absorption interfering with effective problem solving[3]
- high levels of negative feelings[4]
- excessive worry about possible danger or threat[4]
- a sense of being unable to control the threat if it occurs.[4]

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[1] From *Abnormal psychology and modern life* (10th edition) (p. 160), by R. C. Carson et al., 1998, New York, NY: Longman.

[2] From *Study guide to accompany abnormal psychology and modern life* (10th edition) (p. 107), by D. C. Fowles, 1996, New York, NY: HarperCollins College Publishers.

[3] From *Psychiatric dictionary* (7th edition) (p. 52), edited by Robert Campbell et al., copyright © 1996 by Oxford University Press, Inc. Used by permission of Oxford University Press, Inc.

[4] From *Abnormal psychology and modern life* (10th edition) (p. 196), by R. C. Carson et al., 1998, New York, NY: Longman.

COMMON ANXIETY DISORDERS

Separation Anxiety Disorder [5]

In Grade 2, Sunita usually cries at the beginning of each day. She can't be asked a question in the first half hour for fear she will burst into tears. The tears are less likely as the day goes on, although she remains a loner and rarely joins fully into the activities of the day.

Children exhibiting homesickness, school phobia and loner behaviour may be manifesting separation anxiety. A child with this disorder experiences excessive anxiety in relation to leaving home or primary caregivers. The anxiety is beyond what is expected for children this age. The disturbance causes significant distress or impairment in school, social or other important areas of functioning.

When separated from major caregivers, the child wants to know where they are and may wish to stay in touch with them by telephone. When homesick, these children yearn for home and fantasize about the pending reunion with their parents. They are often anxious that their parents will experience accidents or illness during their time apart. They may be reluctant to attend school, visit or sleep at friends' homes or run errands on their own.

Children with separation anxiety disorder tend to come from close-knit families. When separated from their families, these children frequently exhibit social withdrawal, apathy, sadness and difficulty concentrating. Refusal to attend school leads to academic difficulties and social problems. When extremely upset about an impending separation, the child may show anger and physically hit the person trying to enforce the separation. Generally, however, children with the disorder are unusually conscientious, compliant and eager to please. They frequently have depressed moods that may become more serious and persistent over time.

Manifestations of separation anxiety vary with age. Younger children may not express specific fears of threats to parents, home or themselves. As children get older, however, they tend to express more specific worries, such as kidnapping, assault and robbery. Adolescents, especially males, commonly deny anxiety about separation, although it may be reflected in their limited independent activity and reluctance to leave home.

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[5] From *Diagnostic and statistical manual of mental disorders* (4th edition) (pp. 110–112), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

Death or illness of a relative, friend or pet; a geographic move by the family or a change of schools are the life stressors that trigger separation anxiety disorder. Onset occurs from pre-school age to age 18, but is most common in middle childhood (6–11 years). Separation anxiety disorder is equally prevalent among boys and girls, at four per cent. More girls seek help or are brought to professionals for help. While waxing and waning, the disorder may persist for many years. Separation anxiety disorder is more frequent in children of mothers with panic disorder, another of the anxiety disorders.

Overanxious Disorder of Childhood[6]

Carlos, aged 10, is a bright boy, but can always provide a list of reasons why he can't perform a task. It doesn't matter what the task is, Carlos worries that he doesn't know enough to complete it; won't have the time to complete it properly or some calamity will prevent him from doing a perfect job. His worries are expressed irritably or with some degree of sadness at the inevitability of failure, although with a longing to please his teacher.

If excessive, constant anxiety and out-of-control worry about a number of events or activities occur for a period of six months, the diagnosis is likely overanxious disorder of childhood. Anxiety and worry are often accompanied by at least one other symptom, such as:

- restlessness
- being easily fatigued
- difficulty concentrating
- irritability
- muscle tension
- disturbed sleep.

As a result, children experience impaired functioning in school and other important areas. They tend to worry excessively about their competence and the quality of their performance at school or in sporting events, even non-competitive ones. Punctuality becomes an excessive concern. Fears about catastrophes, such as persecution, extreme weather or environmental collapse characterize this disorder.

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[6] From *Diagnostic and statistical manual of mental disorders* (4th edition) (pp. 432–434), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

Children with this disorder are often overly-conforming, perfectionistic and unsure of themselves, tending to redo tasks because of excessive dissatisfaction and less-than-perfect performance. They are typically over-zealous in seeking approval and require excessive reassurance about their performance. Depressed feelings are common.

Over 50 per cent of adults with generalized anxiety disorder (the adult form of this disorder) report onset in childhood or adolescence. The course is chronic but fluctuating and often worsens during periods of stress. As a personality trait, anxiety in children is not strongly correlated to other family members experiencing problematic anxiety. The ratio of diagnosis between girls and boys is approximately three to one.

Post-traumatic Stress Disorder[7]

Jordan was an attentive, industrious student until May and June, when late afternoon storms occasionally developed in a wall of dark cloud. Since the tornado hit the neighbourhood where he used to live, as much as he wants to ignore the cloud bank, he can't seem to help himself from checking on it every few minutes. He soon becomes oblivious to classroom activity.

Post-traumatic stress disorder (PTSD) occurs following exposure to an extreme stressor in which the student experiences, witnesses or is confronted by an event which involves actual or threatened death, or serious injury to self or others. The response involves prolonged increased arousal, intense fear, helplessness and horror, which children express through disorganized and agitated behaviour.

After exposure, children may re-experience the traumatic event through repetitive play, such as crashing toy cars together after involvement in a car accident. They may have nightmares of monsters, of rescuing others or of being in danger. They may display intense psychological distress and physiological reactivity, such as stomachaches and headaches when confronted with symbols of the traumatic event, such as the anniversary, specific weather or specific spaces.

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[7] From *Diagnostic and statistical manual of mental disorders* (4th edition) (pp. 424–426), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

The child may deliberately avoid all stimuli associated with the traumatic event, including people, thoughts, feelings or conversations. This avoidance may lead to decreased interest and involvement in previously enjoyed activities. Ultimately, the child may experience ongoing symptoms of anxiety — detachment from others, sleep disturbance and worries about the future. In some cases, the child may develop amnesia for certain aspects of the event.

Students with PTSD experience significant impairment in academic, social and family-life areas. Symptoms may appear immediately after the trauma or up to six or more months later. Recovery within three months occurs in half of the cases, with a longer recovery time of 12 months or more in others.

Traumatic events affecting children vary from direct to vicarious experiences.

- Directly-experienced traumatic events include: physical or sexual assault, being kidnapped or held hostage, being involved in a severe motor vehicle accident or serious fire, or being diagnosed with a life-threatening illness.
- Witnessed traumatic events include: observing the serious injury or death of another person, major accidents or natural disasters, such as flood, tornado, earthquake, or unexpectedly coming upon a human corpse or body parts.
- Traumatic events that are experienced by other people important to the child include: violent assault, rape, injury or accidental death.

The disorder tends to last longer and be more severe when the stressful event is of human design as opposed to a natural catastrophe. Following traumatic events of human doing, children may withdraw from contact with people. The intensity, duration and proximity to the traumatic event determines the likelihood of developing PTSD.

Individuals with PTSD often experience survivor guilt if others died and if they feel they did not help enough at the trauma scene. Youngsters who have recently emigrated from war-torn areas often have PTSD.

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Acute Stress Disorder[8]

Ms. Selves watched with pleasant surprise as Blaire finally settled back into the classroom routine after finding a mutilated body in the ravine a month before. After two weeks of being disorganized and agitated, Blaire gradually returned to taking turns answering questions, helping with classroom tasks and turning in assignments on time.

Acute stress disorder is a milder form of PTSD. It lasts for at least two days but does not continue beyond four weeks of the traumatic episode. The trigger events and subsequent symptoms are the same as for PTSD. They simply produce a less-sustained response. Persons diagnosed with acute stress disorder are at a higher risk for developing PTSD.

Obsessive-Compulsive Disorder[9]

Chris, a Grade 11 student, becomes anxious whenever small changes at school disrupt his routines. If someone sits in the seat he usually occupies, he becomes upset. He may even worry if someone else sits in a different spot in the classroom. Before settling into his seat, Chris has a routine he feels compelled to follow — he puts down his books and squares them with the upper right-hand corner of his desk, leaves the room for a drink, returns to his desk which he touches three times with his three middle fingers before pausing to look out the back window of the classroom, then returns to his desk to begin the day. During class time, he checks his watch repeatedly against the wall clock and also asks the teacher what time it is. If a student borrows his pen, he does not take his eyes off of it until it is returned. At noon, because he has no friends with whom to relate, he spends time at the same computer playing the same game. Changes in the order of normal class processes, scheduling changes and semester changes are stressful for him.

Obsessive-compulsive disorder, commonly known as OCD, is an anxiety disorder characterized by the persistent intrusion of unnatural thoughts or distressing images. These are most often

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[8] From *Diagnostic and statistical manual of mental disorders* (4th edition) (pp. 429, 430), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

[9] From *Abnormal psychology and modern life* (10th edition) (pp. 182–184), by R. C. Carson et al., 1998, New York, NY: Longman.

accompanied by compulsive behaviours designed to neutralize the obsessive thoughts or images, or prevent some dreaded situation or event.

The word "obsessive" in the name of this disorder refers to thoughts, while the word "compulsive" refers to behaviours. Although OCD generally begins in late adolescence or early adulthood, it is not uncommon in children, where its symptoms are strikingly similar to that of adults (Rapoport, 1989; Swedo et al., 1989). In most cases, the disorder has a general onset, but once it becomes a serious condition, it tends to be chronic, although the intensity of severity waxes and wanes over time. There is virtually no gender difference in a North American lifetime prevalence rate of 2.5 per cent (Robins & Regier, 1991). The rate at which compulsions follow obsessions is high at 90 plus per cent, depending on the study.

Most people engage in obsessive-compulsive behaviours at one time or another, such as re-checking to see if appliances are turned off or the door is locked. In obsessive-compulsive disorder, the intensity of the thought and linked behaviours, and the seeming inability to control them is distressing and affects daily functioning.

Although obsessive thoughts may centre on a variety of topics, the following appear most frequently in studies of OCD:

- contamination (55 per cent); e.g., contracting a disease from germs
- aggressive impulses (50 per cent); e.g., imagining pushing someone into the path of an oncoming vehicle
- the need for symmetry (37 per cent)
- body or physical concerns (35 per cent)
- sexual interest (32 per cent) (Jenike et al., 1986).

The most common compulsive acts used to relieve the distress of the obsessive thoughts are cleaning, checking and counting (Barlow, 1988). Cleaning rituals may involve excessive hand washing. The person may spend 15 minutes washing his or her hands after using the toilet or may spend hours, using strong disinfectants until the hands bleed. Examples of checking rituals range from checking locks three to six times, to spending hours at an intersection looking for signs of an accident one believes one caused. Rituals are usually performed a set number of times. The performance of these rituals usually brings about a reduction in

tension and a sense of satisfaction (Carr, 1971; Rachman & Hodgson, 1980), at least in the short term. But most people with OCD realize that the hours per day they spend on compulsive behaviours is excessive and interferes with social or occupational functioning.

As with all anxiety disorders, OCD frequently occurs with other anxiety disorders (panic, specific and social phobias) and mood disorders, most notably depression (80 per cent over a lifetime) (Barlow, 1988).

Anxiety Disorder Due to a General Medical Condition [10]

Aida's teacher can tell by the fear on Aida's face that her heartbeat is becoming erratic, or that Aida is concerned about it. When Aida suddenly started clearing her desk and lining up her pens and pencils, the teacher knew what was happening without asking — Aida was preparing to die.

When impairing anxiety is directly due to the physiological effects of a medical condition, this anxiety disorder is diagnosed by a physician who first identifies that a medical condition exists, through medical history, physical examination and laboratory findings. The physician also looks for a link between the onset of the anxiety and the onset, exacerbation or remission of the medical condition.

Common medical conditions which may cause anxiety symptoms include:

- endocrine (gland) conditions, such as hyper- and hypo-thyroidism (over or under functioning thyroid gland), hypoglycemia (low blood sugar)
- cardiovascular conditions, such as congestive heart failure (excessive fullness of the blood vessels of the heart), arrhythmia (irregular heart beat)
- respiratory conditions, such as hyperventilation, pneumonia, asthma
- metabolic conditions, such as pernicious anaemia (vitamin B12 deficiency)
- neurological conditions, such as encephalitis (inflammation of the brain).

[10] From *Diagnostic and statistical manual of mental disorders* (4th edition) (pp. 436–438), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

Individuals with anxiety disorder due to a general medical condition may have generalized anxiety (worry about a number of situations), panic attacks (sudden bursts of extreme distress characterized by intense physiological symptoms and fear) and obsessive-compulsive symptoms (repetitive thoughts and behaviours).

Substance-Induced Anxiety Disorder [11]

Carl has no visible concerns in his morning classes. Following lunch, he returns to the classroom appearing agitated and restless, and expresses fears that something is wrong. A fellow student informs the teacher that Carl has used LSD at lunchtime.

Some prescribed medications for children and non-prescription substances, such as tobacco, drugs, alcohol and inhalants used by adolescents, may cause severe anxiety and impaired performance for users in either the intoxicated or withdrawal stages. With this diagnosis, the anxiety symptoms are produced through a recognized physiological process following the intake of a substance, such as medication, drug of abuse or toxin.

Anxiety symptoms that occur during the intoxication phase are related to the use of substances, such as alcohol; amphetamines (uppers); caffeine; cannabis; cocaine; hallucinogens, such as LSD, psilocybin (magic) mushrooms, mescaline, PCP, angel dust or inhalants. Anxiety symptoms that occur during the withdrawal phase are related to the use of alcohol, cocaine, anti-anxiety medication and other substances.

Medications known to produce anxiety symptoms in some individuals include analgesics, anaesthetics, bronchodilators, insulin, thyroid medications, oral contraceptives, antihistamines, steroids, anticonvulsants, anti-psychotic medications and antidepressant medications.

Heavy metals and toxins known to cause anxiety symptoms when inhaled include gasoline, paint, glue, solvents, insecticides and other similar substances.

Anxiety symptoms and behaviours resulting from ingesting or inhaling substances may be generalized anxiety, panic attacks, obsessive-compulsive symptoms or specific phobias.

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[11] From *Diagnostic and statistical manual of mental disorders* (4th edition) (pp. 439, 441), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

PHOBIAS

Specific Phobia [12]

Yoko, 14, missed classes for several days in the fall without explanation. She appeared nervous her last day in class and seemed about to bolt when she did reappear. Several days later, when the announcement was made that the public health nurse was back to give rubella shots to those who missed them earlier, Yoko fainted in class.

Unlike overanxious disorder of childhood in which the child experiences excessive anxiety about a number of events or activities in a number of times and places, the child with specific phobia is fearful of specific objects or situations, or is fearful when anticipating these objects or situations. Fears in childhood and adolescence are common but do not warrant the diagnosis of a specific phobia unless there is significant dysfunction in school or social functioning for at least six months. Children with specific phobias often express their anxiety non-verbally by crying, clinging, freezing or having tantrums. Although adolescents with specific phobia usually recognize their fear is excessive and unreasonable, younger children often do not. Phobias can develop in response to an infinite number of objects or circumstances. Several common types of specific phobia have been identified:

- animal: fear of animals or insects, including reptiles and spiders; usually begins in childhood
- natural environment: fear of objects and events in nature, such as storms, heights, water; generally begins in childhood
- blood-injection-injury: fear of seeing blood, receiving an injection or having medical or dental treatment that results in an "injury," such as stitches to close a wound; highly familial and often accompanied by fainting, generally begins in childhood
- situational: fear of travelling in vehicles over bridges or through tunnels, flying, riding an elevator or escalator, or being in an enclosed space; commonly begins in adolescence.

Experiencing traumatic events, such as being assaulted or involved in a motor vehicle accident, predisposes one to develop specific phobias. Learning about traumatic situations from family and the media may also be a factor in developing a specific phobia.

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[12] From *Diagnostic and statistical manual of mental disorders* (4th edition) (pp. 405–408, 410), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

Having a specific phobia also predisposes a person to other phobias related to the first, such as fear of dogs and lizards. Specific phobias are more often experienced by females. On average, 10 per cent of the population at any one time has phobias significant enough to warrant a diagnosis of specific phobia.

Social Phobia [13]

Joanne, with red face and panicked expression, not only refused to come to the front to deliver her speech, but the teacher was surprised to discover that Joanne had made no effort to write a speech.

Who hasn't experienced stage fright, shyness or tension when meeting strangers? Transient social anxiety and avoidance is common in childhood and adolescence, yet for some it is so marked and persistent that it causes problems with daily routines, functioning at school, and in social and family life.

The central fear of this disorder is being scrutinized by other people, being embarrassed and judged as anxious, weak, crazy or stupid. When exposed to social performance situations with peers and adults, the child may cry, tantrum, freeze or become mute. The child also shrinks from social situations with unfamiliar people in familiar settings, such as visitors at home.

While adolescents usually realize that their fear is excessive or unreasonable, children often do not. Children with social phobia may avoid:

- attending school
- group play
- classroom speaking
- participating in small group activities or discussions
- eating, drinking or writing in public
- using a public restroom
- initiating or maintaining conversations
- speaking with authority figures
- attending parties
- dating.

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[13] From *Diagnostic and statistical manual of mental disorders* (4th edition) (pp. 411–414), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

The child with social phobia usually avoids feared situations and commonly experiences intense anticipatory anxiety before the dreaded social situation. This anticipatory anxiety frequently leads to a self-fulfilling prophecy in which the child's actual performance is diminished by the fear and negative thinking preceding the event.

While some children fear specific social encounters, others generalize their fear to most social situations, whether public or interacting with one other person. These students are likely to have inadequate social skills. They may find it difficult to be assertive, may have feelings of inferiority, be hypersensitive to criticism, be critical of themselves and have poor eye contact. Social support networks are usually small. In more severe situations, students may drop out of school, be unable to interview successfully for jobs, cling to unsatisfying relationships or remain connected solely to their families. In certain cultures; e.g., Japan and Korea, individuals with social phobia may develop persistent and excessive fears of giving offense to others in social situations, instead of being embarrassed. These fears may take the form of extreme anxiety that blushing, eye-to-eye contact, or one's body odour will be offensive to others.

Social phobia usually begins in the mid-teens, often emerging from a childhood of social inhibition and shyness. It may have a gradual or sudden onset following a humiliating experience. With childhood onset, the child fails to achieve optimal social functioning. When the onset occurs in adolescence, social functioning decreases, usually in tandem with performance at school.

Some social phobia symptoms in adolescence are related to having a mental condition or medical disorder, such as severe acne or other dermatological conditions, stuttering, an eating disorder or epilepsy. Social phobia tends to be more common in females than in males.

BIOLOGY OF ANXIETY

There is now a substantial body of evidence implicating biological causes in OCD. This evidence comes from genetic studies, from studies of structural brain functioning and from psychopharmacological studies of various medications and their effects on specific neurotransmitter systems in the brain.[14]

[14] From *Abnormal psychology and modern life* (10th edition) (p. 189) by R. C. Carson et al., 1998, New York, NY.

Although evidence regarding genetic factors in overanxious disorder of childhood is not conclusive, there does seem to be a modest inheritability, as with other anxiety disorders. Recent research suggests that children with overanxious disorder of childhood may have a deficiency in the neurotransmitter GABA which plays a role in how the brain inhibits anxiety in a stressful situation.

In separation anxiety disorder, physical complaints, such as stomach aches, headaches, nausea and vomiting may occur when separation occurs or is anticipated. Cardiovascular symptoms, such as palpitations, dizziness and feeling faint are rare in younger children but may occur in older ones.

The everyday worries of overanxious disorder of childhood are likely to be accompanied by physical symptoms, such as feeling keyed up or on edge, trembling, muscle twitchings and muscle aches. Other physical symptoms include cold clammy hands, dry mouth, sweating, nausea, diarrhea, urinary frequency, a "lump in the throat," headaches and an exaggerated startle response.[15]

In addition to conditioning experiences, genetic and temperamental factors have been shown to have a positive correlation in the acquisition of specific phobias.

Children with social phobia almost always have physical symptoms in feared situations, such as trembling, speaking in a shaky voice, sweating, diarrhea and confusion. Blushing is a particularly common symptom of social phobia.

Recent studies suggest that there may be a link between genetics and social phobia, as there is between temperament, experience and social phobia.

ANXIETY TRIGGERS

Other People's Reactions to Objects or Events

A significant cause of problematic anxiety in children is an over-involved, protective parent who models anxiety for the child over threats and dangers, real or imagined, of daily living. Such behaviour can communicate a lack of confidence in the child's ability to cope without adult support.

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[15] From *Diagnostic and statistical manual of mental disorders* (4th edition) (p. 433), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

Individuals with specific phobia sometimes acquire their phobia by observing another person interacting fearfully with the phobic object or situation.[16] This finding has implications for adults in modelling anxious behaviour in the presence of children and adolescents.

Direct or vicarious conditioning (that is, the child develops the phobia from observing others' negative reactions to a social situation) seems to explain the majority of social phobias.[17]

Seeing or Experiencing a Traumatic or Frightening Event

Life experiences where children feel a lack of control or predictability may predispose them to anxiety in the future. Because children's coping mechanisms grow out of their negative perspectives on the world, these mechanisms may be activated automatically when the child perceives a strange or dangerous situation. In anxiety-prone children, anxiety affects the processing of threatening information in such a way that attention is paid only to threatening cues and not non-threatening ones. Ambiguous information is therefore interpreted as a threat.

Low Self-esteem and Lack of Confidence

The undermining of feelings of competence and security through illness, accident, handicap or losses that involve considerable physical and emotional pain, such as hospitalization, moving away from friends, changing schools, etc., contribute to problematic levels of anxiety in children.

Ongoing Family Tensions and Hostility

Children who are not exposed to growth opportunities or supported enough in those that do exist, such as school, gradually lose self-esteem and self-concept, leading to anxiety, withdrawal and avoidance of threatening situations. Children may feel this way if they sense they are not living up to their parents' excessive expectations.[18]

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[16] From *Abnormal psychology and modern life* (10th edition) (p. 163), by R. C. Carson et al., 1998, New York, NY: Longman.

[17] Ibid., p. 167.

[18] Ibid., p. 544.

Medical and Clinical Treatments

The diagnosis of anxiety disorders should only be made by qualified mental health professionals. Teachers can assist by maintaining accurate records and anecdotal notes regarding observations, student interactions, and evidence of student growth, achievement and behaviour. The information included in this resource on the medical and clinical treatments of these disorders is intended only to raise the awareness of educational personnel and make them more knowledgeable about therapies that students with emotional disorders or mental illnesses may receive outside school. All medical and clinical therapies must be administered and monitored by qualified mental health professionals.

Treating anxiety disorders in childhood is important so that problem behaviours do not grow into increasing avoidance, depression, and idiosyncratic thinking and behaviour in adolescence and young adulthood.[19] Children with anxiety disorders usually respond well to the following therapies and rarely require hospitalization.[20]

Cognitive-Behaviour Therapy

Both cognitive and behaviour therapies come from a common base of learning theory with a focus on symptom elimination or management.

Behaviour therapy includes relaxation, assertiveness and desensitization training in real-life situations and can often effectively address the faulty learning behind children's anxiety disorders, especially specific phobia, social phobia and obsessive compulsive disorder.[21]

Behaviour therapy focuses on eliminating anxiety symptoms and teaching adaptive behaviours. The basic approach involves progressive exposure to the anxiety-producing situation. Students are initially asked to imagine being in the anxiety-provoking circumstance. With the support of the therapist, the student's anxiety gradually abates. The student is then asked to imagine being on the next rung of the anxiety ladder and remaining there until he or she gains control over that level of anxiety.[22]

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[19] From *Abnormal psychology and modern life* (10th edition) (p. 545), by R. C. Carson et al., 1998, New York, NY: Longman.

[20] From *Study guide to accompany abnormal psychology and modern life* (10th edition) (p. 107) by D. C. Fowles, 1996, New York, NY: HarperCollins College Publishers.

[21] From *Abnormal psychology and modern life* (10th edition) (p. 545), by R. C. Carson et al., 1998, New York, NY: Longman.

[22] Ibid., pp. 192–193.

The next level involves moving beyond imagining and relaxing in the therapist's office to real-life exposure in the company of first, the therapist, then a friend, then alone. Students confront their worst fears until the anxiety subsides and they realize their worst fears will not come true and their anxiety will gradually dissipate (Foa & Kozak, 1986). These exposure-type behaviour therapies are particularly useful in treating specific phobia (Butler, 1989; Marks, 1987) and social phobia (Hope & Heimberg, 1993).[22]

Cognitive therapy assumes that people are anxious because of negative thoughts, beliefs and attitudes. First, the therapist helps students identify their automatic thoughts, which are usually irrational and assume worst-case outcomes. Then, they work to change these through logical analysis. Cognitive therapy works especially well for those with social phobia and overanxious disorder of childhood (Barlow, 1993; Hollon & Beck, 1994) but not with specific phobia.[22]

Family Therapy

Because children's lives are so bound up with those of family members, indirect methods, such as family therapy, are often helpful in resolving anxious feelings and behaviours in children.

Family therapy views a child's problems as embedded in the family's problems. The assumption is that if the family's problems are resolved, so are the child's. Family therapy can focus on communication, roles, behaviour control, problem-solving, nurturing, developmental stage, support network, physical and mental health, marital relationships, sibling relationships, environmental factors, ethnicity, ethics and values, coping skills, and world view.

Children in play therapy can benefit from occasional family therapy sessions to help parents keep pace with and support their children's growth. Adolescents are able to engage in individual therapy, although periodic family therapy sessions may be required to deal with issues which young adults cannot resolve on their own.

Group Therapy

Group therapy provides adolescents with opportunities to practise new behaviours and receive feedback from other group members and the therapist in a supportive environment. Group therapies have a range of theoretical orientations but generally include a relationship focus.

Psychodynamic Therapy

Psychodynamic therapy is designed to help students understand themselves, their problems, relationships and place in the world, and help them develop healthier attitudes and better coping skills.

This therapy places a high value on the one-to-one relationship between the therapist and the student, and tends to be long term. The therapy approach is specifically aimed at helping students work through the unconscious conflicts which underlie their symptoms of anxiety.[23]

Play therapy is psychodynamic therapy for children. Play therapy helps children express the troubled parts of themselves through play rather than words. The play therapist observes the play in a room specifically designed for that purpose and infers what the child's conflicts, feelings and excessive emotions might reveal. The development of a positive relationship with the therapist provides the child with a corrective emotional experience, a chance to conquer fears and a secure place to replace anxiety.[24]

Play therapy is effective in treating separation anxiety disorder, overanxious disorder of childhood, post-traumatic stress disorder and acute stress disorder.

Medications

Family physicians or pediatricians often refer children with anxiety symptoms or physical complaints brought on by psychological problems, to psychiatrists. Medication therapy is becoming more widely used for children although questions remain about what drugs are effective and when to use them. An effective approach is often a combination of psychological therapy and medication. A major drawback of medication therapy is that children and adolescents often discontinue the medication because of unpleasant side effects or because they begin to feel better and believe they no longer require it.

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[23] From *Abnormal psychology and modern life* (10th edition) (p. 191), by R. C. Carson et al., 1998, New York, NY: Longman.

[24] Ibid., p. 546.

SCHOOL STRATEGIES TO ASSIST STUDENTS WITH ANXIETY DISORDERS

Teachers can help reduce the negative effects of problem anxiety by teaching and practising soothing coping strategies and helping students "avoid avoiding."

Sammy's teacher makes sure that each morning when she greets him, she checks how he is feeling. If the day isn't looking bright, Sammy and his teacher have a number of pre-arranged options for Sammy. He can share his thoughts with the teacher, listen to quiet music, go to the counsellor's office and talk to her, have a time out in the screened corner of his classroom or model with clay. Time for these activities is monitored carefully and gradually diminished. Once a comfortable and safe climate was established, Sammy was better able to manage his feelings, set goals and eventually respond to a "1, 2, 3 count" without shutting down when he became overwhelmed. Sammy has many ups and downs, and often has to start from square one.

Janie often comes to school crying, saying that she has a tummy ache, headache or that her feelings have been hurt. She frequently asks to go to the washroom or get a drink. Unlike Sammy, Janie tries hard to stay on task, is sensitive and helpful to her peers, and always eager to please her teachers, although often on the verge of tears. Each day, Janie has a chat with her teacher, is acknowledged when she looks vulnerable, and knows that she can share her thoughts when she feels the need.

While both children now come to school more regularly, lateness is still a problem. Janie can enjoy her day, however, and two or three days can go by without an episode from Sammy.

Working with Parents

When students have problems with excessively high performance expectations, teachers must involve parents to help set more realistic goals. Suggest that parents balance or broaden the world view of their highly anxious child both by talking, and by ensuring that they are modelling balance in their own lives. Suggest practical ways for parents to develop positive relationships with their children so that they will feel more comfortable sharing worries with their parents. Help parents modify unrealistically high expectations that may underpin problematic anxiety.

In cases where high separation anxiety exists, teachers may need to reduce or limit parental contact with their children at school. Sometimes parents' over-involvement allows the child to avoid responsibilities, and increases student anxiety and lack of autonomy.

While parents and physicians of preadolescent children make medication decisions for them, adolescents usually have more say in this area. In some cases, school personnel should suggest that parents obtain a mental health assessment in order to help the school and family better understand the nature of the child's anxiety and learn how to provide support at home and school.

Working with Colleagues

Counsellors, administrators, teacher aides and support staff may also assist anxious students.

Referring an anxious student to the counsellor needs to be handled tactfully so as not to arouse further anxiety. Introduce the student to the counsellor by saying, "Ms. S. is a good helper in this area." Another way to introduce the counsellor is to acknowledge that, as a teacher, you need to lean on the counsellor for expertise. Sitting in on the initial meeting with the counsellor may be helpful.

Advocate for students to obtain appropriate educational programs and services, such as home schooling and homebound instruction for periods of acute anxiety. Teachers also need to advocate for maintaining the homeroom concept, especially in elementary schools, as this setting prepares students for the more complex schooling that follows. In the higher grades, advocate for student access to school-based helpers, such as counsellors, school social workers, teaching assistants and special education consultants. Children form relationships with a variety of teachers who must all remain committed to nurturing students beyond curriculum-based activities.

Working with Community Agencies and Mental Health Professionals

Teachers frequently work with agency personnel and mental health professionals. Teachers are often called upon to keep logs, complete checklists and provide anecdotal reports to external practitioners who are treating students for phobias and other anxiety disorders. Sometimes these reports are used by physicians to

monitor and evaluate the effectiveness of a medication regime. Teachers should only share privileged information when parental consent has been given or when legally required to do so.

Classroom Strategies to Assist Students with Anxiety Disorders

Awareness

Teachers must be aware of what problematic anxiety looks like at school. Behavioural cues to excessive anxiety include:

- refusing tasks
- exam-performance anxiety
- reactions to certain school-based sights, sounds and smells
- complaints of freezing
- frequent trips to the washroom
- attendance problems
- repetitive perfection-seeking behaviours
- clinging to parents or teacher.

(Note how some of these cues, such as task refusal and freezing, can be mistaken for oppositional defiant behaviour.)

Setting the Stage — Naming, Sharing

Once aware, be comfortable with naming the anxious feelings for students who may not be able to do so. Naming feelings helps students gain a sense of control over them. In doing so, share a personal story or a story of other students, or have other students who have experienced similar levels of anxiety talk to the student. Be cautious of showing anxiety as this might heighten the student's sense of discomfort.

Teachers can also help by talking with anxious students about:

- the fact that there are things that can be done to deal with their anxiety
- the goals of schooling which are important and cannot be avoided
- the importance of making a commitment to work with the teacher and others to resolve anxious symptoms
- the steps they have taken or would be prepared to take to deal with their anxiety.

Relationship

The relationship between teacher and student is especially critical in the case of overanxious students. Trust develops as teachers extend themselves on behalf of the student without blurring the boundaries

of their role and allowing the student to avoid his or her responsibilities in the classroom. This process takes time and students need to have enough opportunity to verbalize their worries, often repeatedly, in order to gain perspective and understanding. It often takes up to six months for anxious behaviour patterns to be extinguished. Persistence is required to deal with the often entrenched thinking, feeling and behaviour patterns of overly anxious children.

Setting

Jamie's high school exam performance was abysmal. His teacher noticed too much discrepancy between in-class performance and exam results, so he set up some special accommodations for exam writing. Jamie was allowed to write apart from the rest of the class in a quiet office area. He was given extra time, a walkman with music of his choice, and freedom to get up and move about. By changing the setting, Jamie got to the point where his exam performance improved enough that he no longer wanted special accommodations.

Adapting the setting may be helpful in the management of anxiety. A routine, predictable environment does much to support anxious students. Allowing an exam-anxious student to work in a different space may provide enough of a distraction to reduce the stress level. When moving toward an anxious student, try to approach from the front in order to reduce startle response. Physical movement, such as going for a walk in the hallway, running an errand, moving their desks, and going to the washroom to wash their hands, can be used to reduce anxious tension. Art work at a clay/sand table or listening to a story, music or relaxation exercise through headphones can help a student get over an anxiety hump.

Goal Setting

Troy, in Grade 3, needs absolute quiet to even consider becoming involved in a task. His teacher noticed that noise bothers Troy and together they set a goal and made a plan. Troy was to stay in class following the formal lesson and work on the task for five minutes before moving to a quiet area of the school to complete the assignment. Time in class increased as he was able to handle it. In class, Troy uses positive self-talk, as needed, such as, "I'll ignore the sounds that bother me. What do I have to do to ignore the noise? My goal is to work for longer periods of time in the

classroom. I can do it." Over a period of three months, Troy worked to the point of remaining in class the entire time and his anxiety disappeared completely.

In any work with anxious students, goal setting is important. Goals should be set in a step-by-step fashion and progress charted. Subsequent goals can be introduced when the student is ready. When teachers normalize the inevitable regressions, students can be prepared for them.

See Appendix 1, pages 70–71, for a goal-monitoring template: "Student Plan" and a sample completed "Student Plan."

Positive Self-talk

Students need to be taught about the effects of self-talk. Positive self-talk, as seen in the example with Troy, is a consciously focused stream of thinking — an inner conversation that supports students in achieving their goals. Self-talk can also be negative when inner messages erode confidence and hope in the ability to handle the tasks of life. For example, Troy is using negative self-talk if he says to himself, "I won't be able to ignore the sounds that bother me. I have to get away from the noise that bothers me. My goal is to work for a longer period of time in the classroom but I don't think I'll be able to do it." When negative self-talk pervades the inner conversation, over time the erosion of self-confidence generalizes to many situations, further isolating students from their true abilities and others.

Positive self-talk, the antidote to negative self-talk, is a skill that can be taught easily by the classroom teacher. In the case of some students, the concept of the stream of thinking — the inner conversation — may need to be explained before moving into teaching the skills of positive self-talk. Using analogies from every-day life, for example from history, literature, athletics or popular culture, can help a student see how societal heroes would not have been heroic without a certain amount of positive self-talk.

Communication

Communication between the student and teacher needs to be clear and consistent. Arrange eye contact or other physical signals to allow the student to subtly signal the teacher to come to her or his aid. Say, "It seems you are worried today," rather than, "You are worried today," to suggest the student may not necessarily be worried. Start at the student's level of distress and work to reduce threatening tasks to within his or her comfort zone. Anxiety-

provoking situations must be broken down into components which then serve to suggest solutions. Two-to-three minute chats with the anxious student may be helpful outside the classroom once class has begun. Later, in the classroom, an eye contact signal can guide the teacher to approach the student and provide reassurance.

Distractions

Creating distractions is a useful skill for teachers of anxious students. Suggest that older students who have exam anxiety wear mismatched socks or earrings to distract them from obsessing about the exam. Use humour and tokens (like stress-buster candies) to distract anxious students from the stressful task at hand.

Visualization

Visualization is a technique that students may use to overcome potential obstacles. It involves imagining both the anxiety-producing situation and a solution. For example, a student who is fearful of classroom presentations may visualize presenting only to the teacher or a friend.

Reality Checks

Conduct reality checks with anxious students to help them avoid pitfalls that they lack the maturity and experience to see. Help a student with social phobia realize that his or her dream of becoming a sports-caster may not be realistic, but being a sports writer or researcher might be.

Using the Peer Group

The student's peer group is another school-based resource that can help. Buddying an anxious student with a more confident peer, and using circle time to have students brainstorm solutions to hypothetical anxiety-provoking situations are examples of how to use this group as a support for students who are anxious.

Comment on Strategies

This is not an exhaustive list of strategies, but used conscientiously these strategies will have an impact on the crippling anxiety experienced by overanxious students.

RESOURCES

This listing is not to be construed as explicit or implicit departmental approval for use of the resources listed. The writers have provided these titles as a service only, to help school authorities identify resources that contain potentially useful ideas. The responsibility to evaluate these resources prior to selection rests with the user, in accordance with any existing local policy.

Resources listed in this section can be ordered from local bookstores and/or publishers/distributors. See pages 68–69 for addresses for publishers/distributors.

The Anxiety and phobia workbook (2nd edition) (1995) by Edmund J. Bourne. Oakland, CA: New Harbinger Publications Inc. ISBN 1–57224–003–2. Available from the Teachers' Book Depository.

This book provides information about anxiety, and offers coping skills and exercises to overcome panic attacks, agoraphobia, social fears, generalized anxiety, obsessive-compulsive behaviour and other anxiety disorders. It offers step-by-step guidelines, questionnaires and exercises to help people learn new skills and make positive life changes. The workbook can be used as a self-help program or as part of a therapy treatment program.

Coping with anxiety and panic attacks (1997) by Jordan Lee. New York, NY: The Rosen Publishing Group, Inc. ISBN 0–8239–2548–X.

This self-help book is written for teens. It looks at anxiety disorders, panic attacks, phobias and obsessive-compulsive behaviours, and defines common characteristics. It examines the biological and emotional causes of anxiety, and looks at some of the consequences. It offers practical advice for managing stress and depression. It outlines traditional approaches to treating anxiety as well as more recent developments in cognitive and behavioural techniques. The book offers guidelines for when to seek professional help, and contains a glossary and guide for medications used to treat anxiety disorders.

The Don't panic self-help kit: the homework guide to conquering your fears (1997) by R. Reid Wilson. Chapel Hill, NC: Pathway Systems. ISBN 0–9630683–2–6.

This kit is designed for people experiencing severe anxiety attacks or those who fear having panic attacks. The first sections help identify long-term goals, and organize daily and weekly practice. The next five sections outline the skills needed to overcome panic and conquer fears, including challenging basic beliefs and shifting attitudes, learning breathing and relaxation techniques, and mediation and success imagery. The final sections deal with handling worries and physical symptoms. The kit includes four audiotape programs and a set of skill cards. Consumable goal sheets, preparing-to-practice sheets, after-practice and after-panic inventories are also included.

Don't panic: taking control of anxiety attacks (revised edition) (1996) by R. Reid Wilson. New York, NY: HarperCollins Publishers, Inc. ISBN 0–06–095160–5. Available from Pathway Systems.

This book explains how panic attacks happen, what causes them and how they affect people's lives. The author offers a five-step strategy for controlling panic. Breathing exercises, problem-solving skills and focused-thinking strategies are also included. The book outlines 11 ways to control the chronic muscle tensions that increase anxiety and discusses how to master the fear of flying and social anxiety. An evaluation of current medication is included along with eight attitudes that promote recovery so that people can establish reachable goals, and gradually increase their involvement and enjoyment in life.

An End to panic: breakthrough techniques for overcoming panic disorder (2nd edition) (1998) by Elke Zuercher-White. Oakland CA: New Harbinger Publications, Inc. ISBN 1–57224–113–6.

This general reference workbook outlines how to recognize panic attacks and understand their progression. Part one discusses motivation and self-defeat, and when to consider medication. Part two discusses the physiology of fear and panic, and offers step-by-step directions for breathing retraining, and targeting thoughts and beliefs. Part three gives suggestions for challenging and mastering phobic situations. Part four looks at components of success, including accepting feelings and standing up for yourself, coping with stress and general anxiety, and handling setbacks. This resource also includes worksheets and a list of additional references.

The Highly sensitive person (1996) by Elaine N. Aron. Secaucus, NJ: Carol Publishing Group. ISBN 0–553 06218–2 (paperback). Check with your local bookstore.

This book provides self-assessments to help individuals identify particular sensitivities and make sensitivity a character strength rather than a liability. The author offers advice for reframing past experiences in a positive light while improving self-confidence in the process. She discusses how high sensitivity affects both work and personal relationships, and offers tips on how to deal with overarousal. Information on when to seek help and how medication is used is included, as well as tips for teachers working with highly sensitive students.

Mind over mood: change how you feel by changing the way you think (1995) by Dennis Greenberger & Christine A. Padesky. New York NY: The Guilford Press. ISBN 0–89862–128–3.

Targeted at both general readers and professionals, this workbook offers a step-by-step program for overcoming a wide variety of psychological problems, including depression, panic attacks, anxiety, anger, guilt, shame, low self-esteem, eating disorders, substance abuse and relationship difficulties. It contains examples, exercises, worksheets and action plans. The 12 chapters offer advice on understanding problems, identifying and rating moods, and balancing thinking. The authors encourage readers to examine their assumptions and core beliefs, and make action plans. The goal of this book is to maximize limited therapy time and continue the therapeutic learning at home.

The Relaxation and stress reduction workbook (4^{th} edition) (1995) by Martha Davis, M. Elizabeth Robbins Eshelman & Matthew McKay. Oakland, CA: New Harbinger Publications, Inc. ISBN 1–879237–82–2 (paperback).

This resource is both a general reference book and a workbook. It is designed to teach readers the most popular stress management and relaxation techniques and exercises. It gives an overview of stress and teaches techniques for relaxation. Individual chapters discuss time management, assertive communication, options for dealing with environmental and interpersonal stress on the job, the basics of nutrition and exercise, and their relationship to stress management. The final part of the book provides strategies for increasing motivation, dealing with problems that come up along the way and sticking to a plan.

Wherever you go, there you are: mindfulness meditation in everyday life (1994) by Jon Kabat-Zinn. New York, NY: Hyperion. ISBN 1–56282–769–3.

In this book, the author maps out a simple plan for cultivating mindfulness in one's life. This is a practical guide to meditation for both beginners and those who want to expand their practice. The goal of meditation is to enjoy life more fully, more effectively and more peacefully. Part one explores the rationale and background for taking on a practice of mindfulness. Part two explores some basic aspects of formal meditation practice. Part three offers a range of applications and perspectives on mindfulness.

Publisher/Distributor Addresses

Guilford Press, New York, NY U.S.A.
Canadian Distributor:
Login Brothers Canada
324 Saulteaux Crescent
Winnipeg, MB R3J 3T2
Telephone: 1–800–665–1148 or (204) 837–2987
Fax: 1–800–665–0103 or (204) 837–3116

Hyperion, New York, NY U.S.A.
Canadian Distributor:
H.B. Fenn and Company Ltd.
34 Nixon Road
Bolton, ON L7E 1W2
Telephone: 1–800–267–3366 or (905) 951–6600
Fax: 1–800–465–3422 or (905) 951–6601
Web site: http://www.hbfenn.com

New Harbinger Publications, Oakland, CA U.S.A.
Canadian Distributor:
Raincoast Books
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Telephone: 1–800–663–5714 (within Canada)
Fax: 1–800–565–3776 (within Canada)
Web site: http://www.raincoast.com

Pathway Systems
P.O. Box 269
Chapel Hill, NC 27514
U.S.A.
Telephone: 1–800–394–2299
Fax: (919) 942–0700

The Rosen Publishing Group
New York, NY
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P.O. Box 308
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Telephone: 1–800–461–9120
Fax: 1–800–561–1763

The Teachers' Book Depository
18004 – 116 Avenue
Edmonton, AB T5S 1L5
Telephone: 1–800–661–1959
Fax: (780) 451–3958
Web site: http://teachersbooks.epsb.net

Clinics

Anxiety Disorders Clinic
St. Mary's Hospital Centre
McGill University
3830 LaCombe Avenue
Montreal, QC

Free From Fear Foundation
1137 Gloucester Square
Pickering, ON
L1V 3R1

Student Plan

Student Name: _____ Date: _____

Review Date: _____

Goal:

Student's Plan of Action:

Teacher's Observations:

Student/Teacher Follow-up:

Student Plan

Student Name: Troy Smith Date: Monday, March 15, 1999

Review Date: Friday, March 19, 1999 @ 12:45 p.m.

Goal:

My goal is to work for longer periods of time in the classroom.

Student's Plan of Action:	Teacher's Observations:
• *I will try to ignore the sounds that bother me.*	• *Seemed to be able to ignore the noise of the small-group activity in social studies on Monday and Thursday.*
• *I will use positive self-talk. "I'll ignore the sound. I can do it! I will look at the instruction card taped to my desk."*	• *Used positive self-talk. Was observed referring to card in social studies and language arts classes on Monday, Tuesday and Wednesday.*
• *I will move to another space in the classroom to get away from noise.*	• *Tried to ignore sounds by moving to another space in the classroom on three consecutive post-lunch-hour periods — Monday, Tuesday and Wednesday.*
• *I will remove myself from the classroom.*	• *Removed himself from the classroom twice, once by self on Wednesday a.m. and once with a cue from me on Thursday p.m.*
• *I will stay in the class following the formal lesson for at least 10 minutes.*	• *Stayed in class following formal lesson for 10 minutes on three occasions within the past two days and for the remainder of the classes on Thursday and Friday.*

Student/Teacher Follow-up:

March 19/99: Week debriefed. Teacher had to amplify the gains made. For next week, the first three steps of the Student's Plan of action will be retained. Step 4 will be altered to read "only once per day" and Step 5 will be altered to read "15 minutes per day." This revised plan will run from March 22 @ 8:40 a.m. to March 26 @ 12:45 p.m.

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DEPRESSION

Depression is a mood disorder characterized by feelings of sadness, loneliness, hopelessness, worthlessness and guilt. It is the most common of mental disorders but also the most treatable. There are a variety of reliable treatments for depression, including medication and counselling. School staff, particularly school counsellors, psychologists and social workers can work with parents and local mental health agencies to secure appropriate assistance for students experiencing depression.

Although there is assistance available to treat depression, this emotional disorder is often not recognized in children and adolescents and therefore they do not get the help they need. People have difficulty believing children get depressed and it is often hard to recognize the symptoms. Failure to recognize and treat depression can have serious consequences:

- there is a correlation between depression, thinking about suicide, planning suicide and committing suicide
- depression in childhood and adolescence often sets the stage for mental health problems in adult life
- depression affects students' academic achievement and social relationships.

There are several types of depression. Some depression is the experience we all have in response to disappointments in life and it passes within a few days. This may include reactive depression or uncomplicated bereavement which occurs in response to a traumatic event, such as death of a loved one, major illness or change in a person's life, such as moving. This may last from two months to a year, with the anniversary of the event being a sensitive time. The depression is usually understandable to the person and to others in his or her environment. While the symptoms, such as reduced pleasure in activities and sadness are common in this type of depression, they are time limited.

Chronic depression (dysthymia) is a persistent negative feeling or depression that has lasted more than a year in children and adolescents or two years in adults. It is not necessarily triggered by or in response to a particular life event. In children and adolescents, the mood can be described as more irritable than depressed. There may be some good days or parts of days, but the individual has not been without symptoms for longer than two months. At least two of the following symptoms are also seen:

- poor appetite or overeating
- insomnia or sleeping too much (hypersomnia) almost every day
- low energy or fatigue

- low self-esteem
- poor concentration or difficulty making decisions
- feelings of hopelessness.

A person with dysthymia may periodically experience a major depressive episode. This pattern can start with children in the pre-school years.

In a major depressive episode, the child or adolescent must have either a depressed or irritable mood, or loss of interest or pleasure in almost all activities for at least a two-week period. At least three of the following symptoms are present and represent a change for the individual:

- significant weight loss (not due to a voluntary diet) or weight gain, or chronic decrease or increase in appetite
- insomnia or hypersomnia almost every day
- observable psychomotor agitation or retardation nearly every day (is jumpy or clumsy)
- decreased ability to concentrate or indecisiveness almost every day
- recurrent thoughts of death or recurrent suicidal ideation
- feelings of worthlessness or guilt
- loss of energy.

Mania may also co-exist with depression, leading to a diagnosis of bipolar disorder, commonly referred to as manic depressive disorder. Two symptoms to look for in young people are euphoria and hostile anger. Euphoria is an exaggerated elated mood with inappropriate feelings of giddiness and silliness possibly combined with the denial of any problems, despite observations to the contrary. Hostile anger of the manic young person may be ranting rages; impulsive destructiveness or uncontrolled antisocial and homicidal thoughts, threats or attempts. Other symptoms include:[1]

- psychomotor agitation
- rapid speech
- flight of ideas, racing thoughts, the inability to focus on one idea
- grandiosity with heightened self-worth, self-power and self-influence which can be delusional
- sleep disturbance with decreased need to sleep and night time hyper-wakefulness

[1] From "Depression and other affective illnesses as a cause of school failure and maladaptation in learning disabled children, adolescents, and young adults" (p. 4), by W. A. Weinberg, C. R. Harper, G. J. Emslie & R. A. Brumback, 1995, in Learning Disabilities Association, *Secondary education and beyond* (chapter 15), Pittsburgh, PA: Learning Disabilities Association. Taken from web site [http://www.ldanatl.org/articles/seab/weinberg]. Reprinted with permission from the Learning Disabilities Association of America, Pittsburgh, Pennsylvania.

- shortened attention span, inability to concentrate and distractibility
- heightened sexual awareness or activity.

These symptoms are a change from the student's usual behaviour — either a new behaviour or worsening of an existing behaviour that is present for more than one month.[1] It is difficult to diagnose classic manic depression in children because the symptoms are confused with normal variations in childhood development and other related disorders, such as attention deficit hyperactivity disorder.

DEPRESSION TRIGGERS

There is no one cause of depression. Research suggests that there is a dynamic interplay between the following factors that make a person vulnerable to depression:

- specific distressing life events
- biochemical imbalance in the brain
- psychological factors
- genetic links.

Distressing Life Events

A child's sense of security can be negatively affected by family situations such as:

- marital discord
- divorce
- remarriage or co-habitation
- serious illness or death of a parent or loved one
- unemployment and poverty
- abuse — physical, emotional or sexual
- parental psychopathology, including drug or alcohol abuse
- family violence.

The dilemma created by these problems is that they can interfere with the parent's ability to interact with and give emotional support to the child. The child in a family experiencing these difficulties often has fewer opportunities to pursue extra-curricular or extended family activities.

Attending school is another distressing life event for some students. For students with depression, school can constitute a significant stressor because the area of the brain affected by depression is the area that holds functions essential to academic achievement. Children and adolescents with depression often feel they are stupid and the experience of school failure adds credence

to this feeling. Specialized teaching techniques are needed to help these students learn and feel successful.

Social difficulties can also make school an unpleasant experience for some students. Social problems can be a contributing factor to depression or, alternately, a result of depression.

The following seem to act as protective influences against depression:

- high self-esteem
- good coping skills
- school achievement
- involvement in extra-curricular activities
- positive relationships with parents, peers and adults outside the family context.

Biochemical Imbalance in the Brain

Depression in children can also be caused by a biochemical imbalance in the brain. The brain chemicals, seretonin and norepinephrine, are found to be out of balance in individuals with depression. Seretonin and norepinephrine are neurotransmittors which move messages from nerve receptor to nerve receptor. An imbalance of seretonin may cause the sleep problems, irritability and anxiety characteristic of depression, while an imbalance of norepinephrine, which regulates alertness and arousal, may contribute to the fatigue and the depressed mood of the illness. Cortisol, another natural biochemical that the body produces in response to extreme cold, anger or fear, is elevated in anyone living with long-term stress.[2]

Hormones are often blamed for the ups and downs seen in many young adolescents, however hormonal changes that take place in adolescence are not seen as responsible for depressive illness.

Psychological Factors

Individuals with depression tend to get into a negative cycle of thoughts, feelings and perceptions that serve to perpetuate the low mood. When they make mistakes or are ignored, they think, "I'm stupid. I never get anything right. Nobody likes me." They focus on the negative experience and that becomes the only way they see the world. They ignore times when they do something right or

[2] From APA Online Public Information, *Childhood disorders*, by the American Psychiatric Association, 1992, Washington, DC: American Psychiatric Association. Taken from web site [http://www.psych.org/public_info/CHILDR-1.HTM]. Reproduced with permission.

someone is friendly to them. With adolescents, feelings are often normally intense and variable. The difference for adolescents with depression is the intensity and persistence of the negative and pessimistic point of view.

The major biological changes, and the psychological and social shifts that occur in adolescence are difficult to navigate for some young people. The rise in rates of depression for adolescent girls compared to boys has some cultural context. Current emphasis in fashion celebrates the pre-pubescent female form. The result is that the majority of adolescent girls express dissatisfaction with their bodies. "There is strong evidence that girls do not welcome the body transformations (increase in weight and body fat) and the potential for reproduction brought by puberty, whereas boys see their increased height and strength as new positive attributes, associated with feelings of self-attractiveness and confidence" (Tobin-Richards et al., 1983). Research suggests that there is an increase in depression in girls who mature early, especially when tied to transition to secondary school.

As students move to secondary school, they face increased academic expectations in a school structure where they relate to a greater number of adults on a less personal basis than in elementary school. Most students manage these changes successfully but those who have difficulty meeting their academic goals and need greater social supports can develop a spiral of negative thinking and experiences.

Genetic Links

As depression is much more common in children where one biological parent has depression, a variety of studies have been done to determine if there is a genetic connection to depression. So far, it would seem that genetic factors play a major role in bipolar affective disorder disease and to some extent in severe major depressive disorders. Not all individuals who are genetically predisposed to depression actually have a depressive episode.

CHARACTERISTICS

Depression in children and adolescents is not easy to identify. "Some young children with this disorder may pretend to be sick, be overactive, cling to their parents and refuse to go to school, or worry that their parents may die. Older children and adolescents with depression may sulk, refuse to participate in family and social activities, get into trouble at school, use alcohol or other drugs, or stop paying attention to their appearance. They may also become negative, restless, grouchy, aggressive, or feel that no one understands them. Adolescents with major depression are likely to

identify themselves as depressed before their parents suspect a problem. The same may be true for children" (Center for Mental Health Services, 1998). It is necessary to look at the typical symptoms of depression and see how each symptom may be manifested in a child or adolescent, keeping in mind that students with depression do not necessarily exhibit all these characteristics. The following characteristics of depression may appear in children or adolescents. It is important to remember that one symptom will affect another. For instance, if students have trouble getting to sleep and want to avoid people, it is difficult to summon the energy and motivation to maintain regular school attendance.

Difficulty Concentrating and Making Decisions

Typically, students with depression have difficulty concentrating and making decisions. They are likely to have difficulty maintaining the attentiveness necessary for learning. As a result, they have problems processing information and retrieving it. Language learning, especially in younger children, and mathematics learning are affected. Students have a difficult time trying to decide how to complete a complicated project, such as an essay. Teachers may be concerned that students are daydreaming. They do not complete assignments or homework and do not put forth a good effort. Their marks decline and this exacerbates feelings of worthlessness that they are experiencing.

Loss of Interest in Taking Part in Activities

Students with depression withdraw from participation in activities as the ability to anticipate or experience pleasure declines. Sometimes, parents or teachers may persuade or coerce students into participating in activities, however participation does not increase their interest or enjoyment in the activity. They wander at recess, not joining games or interacting with peers. They do not show interest in activities in class that are typically seen as fun or exciting. This is a change from previous behaviour.

Avoiding Other People

Children or adolescents with depression make less effort to participate in group activities or maintain friendships. They are less friendly and outgoing. They question other people's interest in them. They feel it is not safe to trust people, especially with their sadness. They may not acknowledge their feelings even if asked. Students with depression, especially those with learning difficulties, tend to see themselves as socially inept, even more than others observe, and decide that it just is not worth the effort to

try to engage others socially. For instance, when cooperative learning groups are formed, they wait passively to be placed or even resist being placed in a group. Problems with school attendance, such as school refusal, school phobia or cutting classes can be a signal that students are depressed. Depression and anxiety may co-exist in these cases.

Overwhelming Feelings of Sadness or Grief

Low mood and tearfulness, typically thought of as depression, is seen more frequently in adolescents. They cry easily and the sadness seems out of proportion to the apparent source of sadness. They are difficult to console. This overwhelming sadness can be quite frightening to young people with depression. Younger children with depression tend to be lethargic with negative thoughts.

Unreasonable Guilt

Children or adolescents with depression see themselves as more responsible for problems in their environment than they actually are. This ties into the sense of helplessness that can occur in a disturbed family situation. They take on the guilt rather than admit the powerlessness they experience. Guilt also ties into feelings of worthlessness which students express. They say things like, "It's all my fault," or, "I can't do anything right." The guilt, aligned with loss of energy and difficulty concentrating, can immobilize students mentally and emotionally, making it difficult to get any work done.

Loss of Energy

Loss of energy is typical for students with depression. The energy is expressed as mental and/or physical exhaustion. They complain of tiredness. Walk and talk is slowed. The teacher wonders if they are getting enough sleep. This lack of energy corresponds to diminished interest in activities and socialization.

Thoughts of Death or Suicide

While suicide is uncommon in childhood, it does occur. The incidence of suicide rises in adolescence. While not all people who commit suicide are depressed, significant numbers are. Studies indicate that many suicidal people leave clues prior to their attempts. Students may ask questions about what the world would be like without them and talk about how they would take their lives or prefer to die. It is important for adults to remember that adolescents often discuss concerns with friends that they do not

share with parents or teachers. If school staff are concerned that a student may be suicidal, they should maintain contact with the student's friends to carefully determine if there is immediate risk of suicide. An evaluation of suicidal risk by the school counsellor or other mental health professional is warranted whenever depression is suspected. When talking to a student believed to be at risk of suicide, try to determine if the student has an actual plan, the specifics of it and if the student has the means to carry out the plan. It is useful for counsellors to obtain specialized training in suicide intervention available through agencies like the Canadian Mental Health Association. Additional information on suicide can be found in the introduction of this manual.

Feeling Overwhelmed by Small Things

Small things often feel overwhelming to students with depression. They are easily annoyed and hypersensitive to the comments and actions of others. Comments typically seen as corrective feedback or mild joking provoke tears or anger. Because they are not using effective coping strategies, even small problems lead to a sense of panic. The sense of being overwhelmed ties into difficulty concentrating.

Anger and Irritability

Unexplained irritation and frequent complaining are prominent symptoms of depression in children and adolescents. They are quarrelsome, disrespectful of authority, hostile and prone to sudden anger. There is increased shouting and screaming. Students are seen as agitated, demonstrated by the inability to sit still; excessive fidgeting; pulling at hair, skin, clothing or other objects. Alternately there may be some psychomotor retardation — coordination is poor and the student seems clumsy. Because people do not respond positively to anger or irritable types of behaviour, the individual's self-worth is diminished.

Sleep Disturbances

Because sleep disturbances are common with depression, fatigue and loss of energy are understandable. Children and adolescents have difficulty falling asleep or awaken several times during the night. They may awaken up to two hours before normal waking time. Once awake, with everyone else in the house still sleeping, they often dwell on the guilt and hopelessness they feel. Over sleeping in the morning also occurs and creates a problem with school attendance. Hypersomnia, which is sleeping an excessive

amount, also indicates depression. Sleep problems are apparent to the teacher when the student doses off in class, but more often the teacher learns of this problem from parents.

Substance Abuse

When young people abuse drugs and/or alcohol, there is a possibility that they are depressed. They may be trying to escape the sense of helplessness and hopelessness through use of drugs and/or alcohol. However, alcohol acts as a depressant and can adversely affect mood. Drug and/or alcohol use can be difficult for teachers to recognize unless students come to school impaired. There may be themes in students' writing or taste in music, stickers or buttons on binders and clothing that indicate use/abuse.

MEDICAL AND CLINICAL TREATMENTS

The diagnosis of depression should only be made by qualified mental health professionals. Teachers can assist by maintaining accurate records and anecdotal notes regarding observations, student interactions, and evidence of student growth, achievement and behaviour. The information included in this resource on medical and clinical treatments of this disorder is intended only to raise the awareness of educational personnel and make them more knowledgeable about therapies that students with emotional disorders or mental illnesses may receive outside school. All medical and clinical therapies must be administered and monitored by qualified mental health professionals.

Once the diagnosis is made by a mental health professional, treatment may be implemented using a variety of methods. Frequently more than one treatment method is used, for instance medication and family therapy. For the most part, these treatments are provided outside the school setting by the appropriate mental health professional. Understanding the nature of the medical and clinical treatment allows teachers to be supportive to parents and the student.

Medications

Medications may be prescribed by the physician after a careful medical examination which includes determining the type of depression, height and weight, and perhaps family members' response to a particular drug. Antidepressants may be prescribed. New drugs become available regularly. Doctors and pharmacists have information on how medications work and side effects that may occur. For bipolar disorder, antidepressants may be prescribed along with other drugs for mania. These medications

are not addictive. It usually takes two to four weeks to see a positive response to medications and some adjustments may be required to develop the most helpful regime. The use of medications alone cannot be expected to provide a complete recovery. Medications have been found to be less effective with children and adolescents than with adults. This may be in part that side effects can be distressing which can lead to poor compliance in taking medication. This is when patients need to work with doctors to adjust the dosage.

Psychological Therapy

The following psychological interventions may be required:

- cognitive-behaviour therapy
- group therapy
- psychodynamic therapy
- family therapy.

Cognitive-Behaviour Therapy

In cognitive-behaviour therapy, students are encouraged to use self-control, positive self-talk and behavioural problem solving to alter behaviour and improve their mental well-being. Some students with depression are hard on themselves and may feel more inept, either as learners or social beings, than they objectively are. They need to learn to look for positive reinforcement in their environment. Cognitive-behaviour therapy can help students alter a negative cycle of thinking by replacing irrational thoughts, such as, "I never get anything right," to "I got six out of 10 right."

Group Therapy

Group therapy, oriented to building self-esteem, enhancing social skills and managing anger can be helpful for students and may be included in the treatment plan. Group therapy is available through local mental health agencies.

Psychodynamic Therapy

Where students are perceived to have internal emotional conflicts that are causing depression, mental health professionals try to help students look inward to understand and resolve the conflict. Play therapy, art therapy and individual psychotherapy are examples of this type of treatment.[3]

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[3] From "Wednesday's child," by S. Black, 1995, *The Executive Educator*, 17(11), p. 30. Reprinted with permission.

Family Therapy

In family therapy, the entire family is involved as they often need to change their responses to depressed children or adolescents. In some families, children may demonstrate learned helplessness if they perceive that they have little influence over their environment. This happens especially in the case of abuse or neglect. Restoring healthy family functioning is the goal of this form of treatment.[3]

PRACTICES TO ASSIST STUDENTS WITH DEPRESSION

There are health practices that help manage depression. Depending on age, students can be encouraged to take responsibility for using these strategies. If they are young or seriously incapacitated by depression, parents and teachers need to take a more active role in using these strategies to help students regain emotional equilibrium. Some of these practices are common sense but when people are in a depressed state, they are not effective problem solvers and need to be reminded how to take care of themselves. It is important to remember that students will not be able to use all these strategies at once. There may be a tendency to make several suggestions at once. This may be overwhelming and set students up for failure. It is better to start with one or two strategies, see some success, then have them try something else.

The techniques outlined in this section are not universally applicable to all students with depression and should only be implemented by mental health professionals as part of an individualized treatment plan for a particular student.

Get Sufficient Sleep

Disturbed sleep exacerbates depression so it is important for children to have regular sleep schedules. Teenagers often resist this, wanting to stay up late and sleep in on weekends. As much as possible, the person should:

- go to bed around the same time each evening
- establish a routine, such as a bath or warm shower
- eat a snack before bed, such as a bowl of cereal or cup of warm milk
- talk quietly with parents to sort out concerns that have arisen throughout the day
- read quietly
- play relaxing music
- go back to bed if they awaken at night
- use relaxation exercises
- use positive self-talk, such as, "I'll be alright when I get up" or, "I can do this."

Eat Healthy Food

People with depression tend to over or under-eat. Encourage a healthy diet even though children may be more interested in junk food. Research indicates that chocolate releases some of the same brain chemicals as some antidepressants.

Physical Activity

The vicious circle of poor sleep and diet causes people to be lethargic and inactive. Physical activity helps reduce stress and promotes a healthy sleep/wake cycle. Students need to be encouraged to participate in physical activities like walking to feel better.

Relaxation Exercises

Students can be taught to use various types of relaxation exercises including progressive muscle relaxation and visualization.

With progressive muscle relaxation, students:

- start either at the head or toes
- tense one group of muscles at a time for three to five seconds
- notice how that feels
- release the tension
- notice how that feels
- concentrate on the difference between the two sensations.[4]

In creative visualization, students:

- imagine a place where they felt relaxed, calm and happy
- recall all the sensory input
- imagine themselves there, doing something relaxing
- return to reality bringing that warm feeling.

Various relaxation tapes are available commercially to assist students through relaxation processes. Relaxation exercises tend to be more successful two hours after a meal.

Positive Self-talk

All people talk to themselves, reminding themselves what they need to do during the day and how to do it. A certain amount of thinking is a person's evaluation of the world. When people are depressed, this self-talk tends to be negative. Language tends to

[4] Adapted from *Youth coping with stress* (p. 21), by the Canadian Mental Health Association, Alberta South Central Region (Calgary), n.d., Calgary, AB: Canadian Mental Health Association, Alberta South Central Region (Calgary). Adapted with permission.

be overly dramatic, such as "never," "always," "awful" and "terrible," or demanding, such as "have to," "can't" and "should." People with depression can fall into the trap of irrational beliefs that cause problems. In *Thinking, Changing, Rearranging*, 11 of these beliefs are outlined:[5]

- Everybody must love me!
- I must be good at everything!
- Some people are bad — they must be punished!
- Things should be different!
- It's your fault I feel this way!
- I know something bad will happen soon!
- It's easier not even to try!
- I need someone stronger than me!
- I can't help being this way!
- I should get upset about your problems!
- There is only one good way to do it!

These beliefs can be replaced by beliefs that will not cause problems:[5]

- Everybody doesn't have to love me!
- It's OK to make mistakes!
- Other people are OK and I am OK!
- I don't have to control things!
- I am responsible for my day!
- I can handle it when things go wrong!
- It is important to try!
- I am capable!
- I can change!
- Other people are capable!
- I can be flexible!

With coaching, students learn to stop irrational thoughts and replace them with rational thoughts.

Thought Stopping

Another technique that students can learn is thought stopping. When thoughts come into students' heads that cause them to become upset, they say, "STOP — I'm not going to think about that right now," to themselves. Then they set aside a time, for instance, half an hour later in the day, to do their worrying and crying as well as some problem solving.

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[5] From *Thinking, Changing, Rearranging: Improving Self Esteem in Young People* (pp. 33–38, 51–52), by J. Anderson, 1981, Timberline Press, Inc., P.O. Box 1056, Gig Harbor, WA, 98335. Reproduced with permission.

School Strategies to Assist Students with Depression

Judging by statistics on the incidence of depression in children and adolescents, it is likely that teachers will encounter students with depression. This is more likely in any class for students with learning disabilities. In these classes, often one or more students are dealing with depression. Teachers need to be aware that students in gifted classes may also struggle with depression. When teaching students with a variety of learning needs, teachers need to be concerned about how to help students with depression. Suggested strategies fall into the following categories:

- creating an inviting classroom
- problem-solving strategies
- building a support network
- working with parents
- goal setting
- organizational strategies
- classroom strategies.

These strategies are helpful to all students, but necessary in order for students with emotional problems to experience success at school.

Creating an Inviting Classroom

Creating an inviting environment where students feel safe to take healthy risks is important, as students with depression avoid school if they feel threatened or insecure there.

Teachers need to:

- believe that they make a difference in the lives of students and that all students learn something in their classrooms
- demonstrate unconditional acceptance of students, though not necessarily their behaviours; this is vital to students with depression
- be good listeners
- keep in mind that the emotional feel of the classroom is powerful, especially to students with depression
- avoid singling the student with depression out from the rest of the class
- keep a positive tone; humour is great but sarcasm is hurtful
- keep suggestions for improvement constructive and specific
- avoid over-generalizing, using words like "always" and "never"
- be specific in providing feedback about when, where, how and why, either behaviour or academic work needs to improve

- develop routines or rituals that are conducive to learning. "Rituals are activities repeated in the classroom to create a desired emotion or mindset in the learner and communicate: 'what's important here.' . . . How the teacher deals with homework, grades, attendance, discipline, questions, humour, etc., are examples of rituals" (Phillips, 1992). Some examples are:
  - greet students at the door
  - conduct "getting-to-know-you activities" at the beginning of the year
  - have students work together to create classroom rules or mission statements
  - reinforce rules by reviewing them with students and, when necessary, reminding them of how well they work.

Problem-solving Strategies

Depression is like a curtain that surrounds people and they can barely see any light. As a result, they see few solutions to problems. Teaching students to use problem-solving strategies gives them the opportunity to see other possibilities. A suggested format for problem solving is:

- What is the problem? (Phrased in neutral terms, no blaming.)
- What can I do? (List both positive and negative solutions.)
- Evaluate the solutions. (Is it safe? Is it fair? Will it work? How will people feel?)
- Choose a solution and carry it out.
- Evaluate the situation. (Is it working? If not, what can I do now?)[6]

Sometimes, students pick solutions but do not know how to carry them out. For instance, if the problem is a lack of friends, they may decide one option is to start a conversation with a particular classmate who seems receptive, but they don't know how to begin. Some coaching is required so they can figure out what to do, such as approaching the person when he or she is alone at recess, making eye contact, asking the other person a question about his or her interests, or asking if he or she wants to play.

Class-wide social skills coaching, using resources such as Lions-Quest materials, *Second Step, Thinking, Changing, Rearranging* or *Toward a Safe and Caring Curriculum*, helps all students.

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[6] From *Second step: a violence prevention curriculum — teacher's guide (grades 4–5)* (p. 37), by Committee for Children, 1997, Seattle, WA: Committee for Children. Reprinted with permission.

It may seem easier to integrate these resources at the elementary level but there are also resources for use in junior and senior high school. The concepts may be taught in health, language arts or social studies and need to be reinforced by other teachers throughout the school day. See also *Teaching Students with Learning Disabilities* (1996), Book 6 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, pages LD.200–209.

Another problem-solving strategy is to hold class meetings as outlined in *Positive Discipline in the Classroom*. Students learn the following format for the meetings:

- compliments and appreciation
- follow-up on prior solutions
- agenda items
- share feelings while others listen
- discuss without fixing
- ask for problem-solving help
- future plans (field trips, parties, projects).[7]

Holding classroom meetings at least once a week provides a vehicle for students with depression to participate in problem solving when they are ready to reach out.

Building a Support Network

Students need to be encouraged to build a network of support from parents, teachers and friends. As much as they are able, they need to let people know how they are doing. At school, they may choose a teacher or counsellor to be an advocate to assist them in communicating with their other teachers. If an outside mental health professional is involved, permission needs to be obtained from parents and students, depending on their age, to have this person talk to school staff.

Encourage the student with depression to do the following.

- Maintain contact with a few friends by talking to them regularly and participating in activities that have been part of their regular routine. The student may not get as much enjoyment out of these activities as in the past, but once he or she is feeling better, will be able to get more fully involved.

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[7] From *Positive discipline in the classroom: developing mutual respect, cooperation, and responsibility in your classroom* (p. 55), by J. Nelsen, L. Lott & H.S. Glenn, 2000, Roseville, CA: Prima Publishing. Copyright © 2000 by Jane Nelsen, Lynn Lott and H. Stephen Glenn. All rights reserved. Reprinted with permission of Prima Publishing from the book *Positive Discipline in the Classroom, Rev. 3rd Ed.* (Prima 2000). To order this book, call Prima at (800) 632–8676 or visit Prima's website at [www.primalife.com].

- Use assertive communication rather than fighting or shouting when irritated. For instance, the student could say, "I don't like it when you pull on my jacket. Keep your hands to yourself."
- Walk with a friend, an older buddy or a teacher during recess or breaks. This minimizes the feeling of being left out when the student sees other students having fun or seeming to have many friends.

Not everyone needs or wants to know what the student with depression is experiencing, but hopefully the student has one or two people with whom to talk and laugh. Laughter is a great stress reliever.

Working with Parents

Supportive teachers and parents willing to recognize this problem and access treatment are key to the early intervention and successful treatment of depression. Students need reassurance that they will get better and that depression is a treatable and time-limited condition. Teachers and parents can help by removing unnecessary stressors, and keeping assignments and expectations in line with the student's ability to concentrate and complete tasks. Extra assistance in planning, maintaining routines and decision making may be required. Obtaining reliable information so that the home and school can work together is helpful.

The following are ways that school staff can support parents whose children are depressed.

- Identify one teacher or the counsellor to act as the student's advocate/assistant to help with problem solving.
- Create a team with school staff, parents and the treating professional.
- Maintain communication between home and school. Keep the tone factual and positive, especially noting when improvement is seen. Parents may be discouraged if their children have an emotional disorder. All side effects of medication should be reported to parents and the supervising physician. This is especially important with adolescents who may have poor compliance when taking medication as they have little tolerance for side effects.
- Encourage students to use positive self-talk when dealing with family members. Students may feel theirs is the only family with problems. Reassure them that is not the case and that problem solving can be used to work out particular difficulties.

- Encourage parents to take an active interest in their children, spend time with them and keep the lines of communication open.
- Encourage parents to limit the time children spend watching television or playing computer or video games. Staying up late into the night with these activities creates a poor sleep/wake cycle.
- Check with local mental health agencies to determine if support groups are available for students and/or parents.

Goal Setting

For severely depressed students, little is motivating and it is difficult for them to keep up with the rest of the class. Until the treatment starts to take effect, it is important to demonstrate acceptance and focus on students' accomplishments.

Goal setting helps give direction to people's lives. When students are depressed, the goals may be short term, even one day at a time, in order to be manageable. Students use positive self-talk to acknowledge they are working toward and achieving their goals. This works even if the goal is simply to get to school on time. If they have not been getting to school regularly, this is a big accomplishment.

Help students set short-term achievable goals. Acknowledge when a goal is achieved and encourage students to reflect on what they did to realize the goal. This helps them believe in their own ability to improve their lives.

If the depression is severe, it is helpful to create an individualized program plan (IPP). This establishes realistic expectations, sets goals and acknowledges that students may not make a year's academic growth in the school term. The resource, *Individualized Program Plans*, Book 3 of the *Programming for Students with Special Needs* series, provides detailed information on developing IPPs.

Organizational Strategies

Students may need help keeping materials and assignments organized. All students benefit from instruction in this regard. Resources, such as *Skills for School Success*, are useful for teachers and students.

The following are strategies to help students get organized.

- Have students use agenda books or day-timers for assignments and tests. For example, say, "Write this in your agenda book," each time an assignment is given. Memory is not reliable when a person is depressed.
- Help keep desks, binders, knapsacks and lockers organized. Make this fun by creating a catchy title for the activity, such as "The Great Canadian Locker Clean-up" or make it an activity for homework club.
- Encourage students to use positive self-talk and problem solving when confronted by difficult work. Teachers can model this by talking about times when they used positive self-talk to overcome challenging situations. Before students begin assignments, encourage them to take a deep breath and build confidence by saying to themselves, "I can do it. It's important to try," or "It's OK to make mistakes." Displaying posters with these slogans can be helpful. Use the problem-solving format to handle problems in the classroom. For instance, say out loud, "What can we do here — we have a 20-minute assignment and only 15 minutes left in class?" Work through possible solutions to show students that others use problem solving.
- Help students organize assignments, especially complex projects or essays. Students benefit from assistance in clarifying the expectations of projects, delineating the topic, understanding the steps required to complete the project and setting timelines. Check periodically to determine progress and provide encouragement. Normally, as students mature, teachers expect students to take the initiative to request help, however this can be challenging for students with depression. In these cases, it is more helpful for teachers to take the initiative.
- Tape to the desk a small card with these questions: What am I supposed to be doing? Am I doing it? How did I do? This cognitive monitoring helps keep students focussed.

For more suggestions, see *Teaching Students with Learning Disabilities*, Book 6 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, pages LD.109–136 and *The Parent Advantage* by the Special Education Branch of Alberta Education and the Learning Disabilities Association of Alberta, pages 3–18.

The counsellor or teacher/advocate should use professional judgement to respect confidentiality while letting other teachers know what to look for, what to reasonably expect from students with depression and which strategies will be most helpful.

Classroom Strategies

Teachers will find the following suggestions helpful in their interactions with students with depression. Teachers are not responsible for providing therapy but can use these suggestions to help students in class and with peers.

- Maintain a pleasant, interested tone and be prepared to listen; do not press students for details on family problems or therapy.
- Initiate conversation during seat work, upon arriving, leaving or in the hall, as students with depression are not likely to do so.
- Find out what motivates students, such as working with pets or younger students and how they learn best.
- Use advance organizers when presenting work. Have handouts or put outlines on the board of the day's activities, outlining the objectives. Do this for the whole day and for each subject. For example, the instructions may be, "Today we are going to write a descriptive paragraph by going through the following steps: a,b,c,d." This becomes a study guide. It helps reduce students' anxiety about what is expected of them and they know what to attend to.
- Stimulate as many senses as possible when teaching, including emotions, by playing appropriate music, using posters with steps to follow, creating pictures in the mind.
- Use motivators, such as contests or extra marks to maintain interest.
- Check regularly to ensure class assignments are done.
- Stop by student desks during seat work or sit in on small groups.
- Make accommodations for assignments and exams, such as:
  - have someone read tests aloud to the student
  - use scribes
  - allow the student to go to a quiet space
  - expand the time allocation.
- Use computers.
- Use a variety of assessment methods.
- Be aware of various learning problems.

- Build on academic strengths.
- Appropriately recognize completed work, keeping in mind too much enthusiasm may be frightening. Students with depression may feel great pressure to achieve and become overwhelmed.

RESOURCES

This listing is not to be construed as explicit or implicit departmental approval for use of the resources listed. The writers have provided these titles as a service only, to help school authorities identify resources that contain potentially useful ideas. The responsibility to evaluate these resources prior to selection rests with the user, in accordance with any existing local policy.

Resources listed in this section can be ordered from local bookstores and/or publishers/distributors. See pages 107–108 for addresses for publishers/distributors.

For Teachers

Building self-esteem with Koala-Roo can-do (1989) by Laura Fendel. Glenview, IL: Scott Foresman and Company/Good Year Books. ISBN 0–673–38080–7. ECS–Grade 3. Available from Mind Resources Inc.

This text provides ideas and activities for developing a positive classroom atmosphere. Patterns and reproducibles include games, posters, clip art, borders, puppets and letters to parents. Some users may have concerns about the language used in referring to persons with disabilities.

Classroom rituals for at-risk learners (1992) by Gary L. Phillips; Steve Bareham & Melanie Chandler (eds.). Vancouver, BC: EduServ Inc. Available from the Teachers' Book Depository.

This book introduces techniques teachers can use to influence the emotions, sensory associations and mindsets of learners. The author outlines communication strategies that start with emotion rather than information, tell a story, create remembered associations and make the unconscious conscious. The author encourages teachers to make 80 per cent of communication sensory and 20 per cent emotion to better match the way many students process information and make meaning. The final chapter links this type of communication with brain research.

Esteem builders: a K–8 self esteem curriculum for improving student achievement, behavior and school climate (1989) by Michelle Borba. Torrance, CA: Jalmar Press. ISBN 0–91519053–2. ECS–Grade 8. Available from the Teachers' Book Depository.

An ECS–Grade 8 program that uses five building blocks of self-esteem (security, selfhood, affiliation, mission, competence) as a base. Includes over 250 grade-level, curriculum-content, cross-related activities, assessment tools and a checklist of educator behaviours for modelling. Contains instantly usable award designs for certificates, buttons and posters, a 40-week lesson planner and extensive bibliography.

Feeling good about yourself: strategies to guide young people toward more positive, personal feelings (1990) by Debbie Pincus. Torrance, CA: Good Apple, Inc. ISBN 0–86653–516–0. Grades 3–8. Available from Artel Educational Resources Inc.

This resource for teachers of Grades 3–8 contains 45 activities designed to promote self-confidence as well as encourage expression through art, oral expression and writing. Through reproducible worksheets, students complete activities focusing on how to be responsible for feeling good, becoming aware of their beliefs and feelings, and thinking responsibly. The book contains activities that encourage students to develop responsible attitudes and feelings, gain approval the responsible way, and handle criticism effectively.

Individualized program plans (IPPs) (1995) Book 3 of the *Programming for Students with Special Needs* series by the Special Education Branch of Alberta Education. Edmonton, AB: Alberta Education. ISBN 0–7732–1838–6. ECS–Grade 12. Available from the Learning Resources Distributing Centre.

This resource describes a process for IPP development and includes strategies for involving parents. It provides information on writing long-term goals and short-term objectives. Forms and checklists are included to assist in planning. Transition planning is also addressed, along with case studies and samples of completed IPPs.

Positive discipline in the classroom: create a classroom climate that enhances academic learning, use class meetings and other positive discipline strategies effectively (1997) by Jane Nelsen, Lynn Lott & H. Stephen Glen. Rocklin, CA: Prima Publishing. ISBN 1–55958–311–8. Available from the Teachers' Book Depository.

This manual for teachers outlines how students can learn a number of social skills through the class-meeting process. Class meetings provide students with opportunities to learn to listen, take turns, hear different points of view, negotiate, communicate and take responsibility for their own behaviour. Class meetings give students and teachers a forum for discussing moral, ethical and behavioural issues, and working together to solve problems. The authors encourage teachers to focus on solutions instead of punishment, and offer practical advice on how to communicate caring and help children develop better communication and problem-solving skills.

Second step by the Committee for Children. Seattle, WA: Committee for Children. ECS–Grade 9.

Second Step is a social skills program that uses photos to help students learn to identify problems, evaluate solutions and generate steps to handle difficult social situations. The three units focus on skills in the areas of empathy, impulse control and anger management. Using role play, students learn to understand their own and others' emotions, and how to manage angry feelings. The kit includes laminated photo cards with the teacher's script written on the back. A one-day training workshop is recommended for staff using this resource.

Skills for action (1998) by Lions-Quest Canada. Newark, OH: Quest International. Grades 9–12. Available from Lions-Quest Canada.

Created to help young people become responsible citizens, this program uses a service-learning approach. Students identify issues of community concern, then plan and carry out service projects or placements. Through these activities, they build a personal profile of their skills, talents, abilities and interests. The material can be used as a major component of the career and life management course or the service-learning component can be used in any subject with an out-of-school component. An intensive two-day workshop prepares participants to implement the program.

Skills for adolescence (1998) by Lions-Quest Canada. Newark, OH: Quest International. Grades 6–8. Available from Lions-Quest Canada.

A resource for the health curriculum, this program uses cooperative groupwork strategies to help students build self-confidence and communication skills, manage emotions in positive ways, improve peer relationships, strengthen family relationships and set goals for healthy living. A community service component fosters a wide range of reciprocal relationships with the community. Teachers attend a two-day introductory inservice workshop prior to implementing the program.

Skills for growing (1998) by Lions-Quest Canada. Newark, OH: Quest International. ECS–Grade 5. Available from Lions-Quest Canada.

This social and personal skills development program serves as a principal resource for the health curriculum. It also contributes to selected social studies topics and the seven thematic units can be utilized in language arts. The program helps students develop positive behaviours, such as self-discipline, good judgment and taking responsibility. Healthy lifestyle, and commitment to family and community are promoted. Teachers receive two days of intensive training prior to implementing the program.

Skills for living: group counseling activities for young adolescents, volume one (1990) by Rosemarie Smead Morganett. Champaign, IL: Research Press. ISBN 0–87822–318–5. Grades 4–9. Available from the Teachers' Book Depository.

This manual contains counselling agendas and step-by-step procedures for conducting skill-building groups with students10–14 years old. Learning experiences are based on counselling techniques, including role playing, social skills training and self-improvement exercises. Topics include dealing with divorce, friends, assertive communication, self-esteem, stress and anger management, school survival, and coping with grief and loss. The appendices include pretests and post-tests for each topic area, needs assessment forms, sample letters, consent forms and ethical guidelines for group counsellors.

Skills for living: group counseling activities for young adolescents, volume two (2000) by Rosemarie Smead Morganett. Champaign, IL: Research Press. ISBN 0–87822–420–3. Grades 4–9.

Part one provides specifics do's, don'ts and other guidelines for running a successful counselling group for young people 10–14 years old. Part two contains detailed procedures for conducting groups on eight topic areas, including managing friendships, transition issues, dating, tolerance of cultural differences, relationships at home, cognitive coping skills, managing anger and issues from a male perspective. Learning experiences are based on counselling techniques, such as role playing, social skills training and self-improvement exercises. The appendices include pretests and post-tests for each topic area, needs assessment forms, sample letters, consent forms and ethical guidelines for group counsellors.

Skills for school success (books 3, 4, 5, 6) (1991) by Anita Archer & Mary Gleason. North Billerica, MA: Curriculum Associates. Grades 3–6. Available from Asquith House Ltd./Michael Preston Associates.

This series of books integrates language arts and content curriculum areas for students in Grades 3–6. Students learn how to:

- organize notebooks
- maintain calendars of assignments
- complete well-organized papers
- follow directions
- take notes from lectures and written material
- study for and take tests
- use a table of contents, glossary and index
- develop skills in reading and interpreting graphs and tables
- alphabetize and interpret dictionary and encyclopedia entries.

The teacher guides offer introductory lessons and review activities with over 50 reproducible pages of checklists, reference sheets, parent letters, review games, award certificates and class posters. The consumable student books include work pages for teacher-directed lessons.

Teaching students with learning disabilities (1996), Book 6 of the *Programming for Students with Special Needs* series by the Special Education Branch of Alberta Education. Edmonton, AB: Alberta Education. ISBN 0–7732–1799–1. ECS–Grade 12. Available from the Learning Resources Distributing Centre.

This resource provides practical strategies for regular classroom and special education teachers. Section one discusses the conceptual model and applications for the domain model. Section two includes identification and program planning, addressing early identification, assessment, learning styles and long-range planning. Section three contains practical strategies within specific domains, including metacognitive, information processing, communication, academic and social/adaptive. Section four addresses other learning difficulties, including attention-deficit/hyperactivity disorder and fetal alcohol syndrome/possible prenatal alcohol-related effects. The appendices contain lists of annotated resources, test inventories, support network contacts and blackline masters.

Thinking, changing, rearranging: improving self-esteem in young people (1981) by Jill Anderson. Eugene, OR: Timberline Press. ISBN 0–9608284–0–0. ISBN 0–9608284–1–9 (teacher's guide). Grades 5–12.

Based on rational-emotive therapy, *Thinking, Changing, Rearranging* encourages children to examine their own thinking, inner language and belief systems to learn for themselves how they go about creating their own experiences. Topics include where does hurt come from, discerning beliefs from facts, how language relates to feelings, irrational beliefs that can cause emotional pain, letting go of beliefs that cause problems, and replacing junk-thought with new language. This book could be a tool in counselling small groups or individual students from the age of 10 onward. A teacher's guide with worksheet masters and student workbooks are also available.

Thinking, feeling, behaving: an emotional education curriculum for children / Thinking, feeling, behaving: an emotional education curriculum for adolescents (1989) by Ann Vernon. Champaign, IL: Research Press. ISBN 0–87822–305–3 (Grades 1–6). ISBN 0–87822–306–1 (Grades 7–12).

This curriculum consists of two volumes — one for Grades 1–6 and one for Grades 7–12. Based on the principles of rational emotive therapy, this curriculum suggests ways students can overcome irrational beliefs, negative feelings and attitudes, and the negative consequences that may result from these beliefs and attitudes. Each resource contains 90 field-tested activities arranged by grade levels. The activities include simulation games, stories, role plays, written activities, brainstorming and art activities. The activities are organized into five categories: self-acceptance, feelings, beliefs and behaviour, problem solving/decision making, and interpersonal relationships. *Thinking, Feeling, Behaving* is designed for use in the classroom or in small-group settings and can also be adapted for use in individual counselling.

Toward a safe and caring curriculum (1999) by The Alberta Teachers' Association. Edmonton, AB: The Alberta Teachers' Association. ECS–Grade 12.

This project is part of the Minister's Safe and Caring Schools initiative. Curriculum support materials, including detailed lesson plans, are prepared by Alberta teachers. They adapt and extend the Lions-Quest materials so they can be incorporated into the Alberta programs of study from ECS to Grade 12. The mission of this project is to encourage school practices which model and reinforce socially responsible and respectful behaviours so that learning and teaching can take place in a safe, secure and caring environment. The five topics covered are: building a safe and caring classroom, developing self-esteem, respecting diversity and preventing prejudice, managing anger and dealing with bullying, and working it out together.

Tests

Teacher alert system: a guide for teacher managed assessment of students who are "at risk" of school failure (1991) by the Special Education Branch of Alberta Education. Edmonton, AB: Alberta Education. ISBN 0–7732–0476–8. ECS–Grade 12. Available from the Learning Resources Distributing Centre.

Teacher Alert System (*TAS*) helps teachers identify students who might be at risk of school failure. The behavioural index lists behaviours of concern, and guides teachers to indicators and checklists in the following areas:

- family and welfare issues (abuse and neglect, sexual abuse)
- school and classroom environment (teacher stressors, school security)
- physical/sensory disorders (allergy, blood sugar, eating, hearing, vision, seizure)
- developmental and learning disorders (learning disabilities, ADD/ADHD, language learning, severe communication)
- temperament and behaviour disorders (learning styles, anxiety, avoidant behaviours, conduct problems, potential dropouts, risk of suicide).

Teacher intervention practices (TIPS): a companion document to the teacher alert system (1992) by the Special Education Branch of Alberta Education. Edmonton, AB: Alberta Education. ISBN 0–7732–0720–1. ECS–Grade 12. Available from the Learning Resources Distributing Centre.

Teacher Intervention Practices (TIPS), a companion to *TAS*, helps teachers determine what type of intervention framework is effective and includes specific tactics for intervention. The intervention framework includes a management process and ways to develop community support. The behavioural index guides teachers to specific issues related to family and welfare, school and classroom environment, physical/sensory disorders, developmental and learning disorders, and temperament and behaviour disorders. Each issue includes a list of indicators, criteria for action, possible reasons for the behaviour, prevention, early intervention and sources of support.

For Students and Parents

Chicken soup for the teenage soul: 101 stories of life, love and learning (1997) by Jack Caufield, Mark Victor Hansen & Kimberly Kirberger. Deerfield Beach, FL: Health Communications Inc. ISBN 1–55874–463–0 (paperback). Available from local bookstores.

This collection of cartoons, essays, poems and short stories is designed to help young people set goals, persevere and accept themselves. It includes pieces by Robert Fulghum, Bill Cosby, Ralph Waldo Emerson and Helen Keller, as well as many poems and essays by teens. Chapters focus on relationships, friendship, family, love and kindness, learning, tough stuff, making a difference, and going for it.

Life choices: healthy and well (1996) by Judith Campbell. Scarborough, ON: Prentice Hall Ginn Canada. ISBN 0–13–244195–0 (student resource). Grades 10–12.

This magazine-style publication is aimed at high school students. This issue focuses on health and has short illustrated articles on optimism, exercising the brain, how to stop being self-critical, overcoming bad moods, self-talk, stress, dealing with depression, nutrition, fitness, sexuality and reducing health risks. A teacher's guide is also available.

Life choices: relationships (1996) by Judith Campbell. Scarborough, ON: Prentice Hall Ginn Canada. ISBN 0–13–242173–9 (student resource). Grades 10–12.

This magazine-style publication is aimed at high school students. This issue focuses on relationships and has short illustrated articles on self-image and the beauty myth, peer pressure, communication within families, becoming a better listener, decision making, sexual rights and responsibilities, violence and abuse, loss, and ending a relationship. A teacher's guide is also available.

The Parent advantage: helping children become more successful learners at home and school, grades 1–9 (1998) by the Special Education Branch of Alberta Education and the Learning Disabilities Association of Alberta. Edmonton, AB: Alberta Education. ISBN 0–7732–9886–X. Grades 1–9. Available from the Learning Resources Distributing Centre.

This resource for parents contains strategies for teaching organizational, reading, writing, spelling, math, test taking and project skills at the Grades 1–9 levels. These strategies parallel strategies included in *Teaching Students with Learning Disabilities*, Book 6 of the *Programming for Students with Special Needs* series.

Teen esteem: a self direction manual for young adults (1989) by Pat Palmer with Melissa Alberti Froehner. San Luis Obispo, CA: Impact Publishers. ISBN 0–915166–66–6. Grades 7–12. Available from the Teachers' Book Depository.

Teen Esteem encourages young people to develop refusal skills and positive attitudes so they can better handle peer pressure, substance abuse, sexual expression, growing independence and other challenges. The book offers ideas for goal setting, assertive communication, decision making and feeling good. It encourages teens to know their personal rights, avoid manipulation, and take charge of their own freedom and responsibility.

Video Resources

The Power of choice: depression and suicide (1990) by Live Wire Publishers. San Francisco, CA: Live Wire Publishers. Grades 9–12. Available from the Canadian Learning Company.

Comedian and teen counsellor Michael Pritchard interviews groups of teens across the United States about what to do if they or someone they care about is at risk of suicide. Geared for young people between 15–18, this video identifies the signs frequently exhibited by people who are at risk of suicide, and discusses the recommended procedures for intervening. In addition, it examines ways of coping with depression and stress. This is one of a series of videos that explores the challenge of making positive choices in a complicated world.

Publisher/Distributor Addresses

The Alberta Teachers' Association
Barnett House
11010 – 142 Street
Edmonton, AB T5N 2R1
Telephone: 1–800–232–7208 or (780) 447–9400
Fax: (780) 455–6481
Web site: http://www.teachers.ab.ca/index.html

Artel Educational Resources Inc.
5528 Kingsway
Burnaby, BC V5H 2G2
Telephone: 1–800–665–9255
Fax: (604) 435–1955

Asquith House Ltd. / Michael Preston Associates
94 Asquith Avenue
Toronto, ON M4W 1J8
Telephone: (416) 925–3577
Fax: (416) 925–8823

Canadian Learning Company
95 Vansittart Avenue
Woodstock, ON N4S 6E3
Telephone: 1–800–267–2977 or (519) 537–2360
Fax: (519) 537–1035
Web site: http://www.canlearn.com/default.htm

Committee for Children
Suite 500, 2203 Airport Way South
Seattle, WA 98134–2027
Telephone: 1–800–634–4449 or (206) 343–1223
Fax: (206) 343–1445

Learning Resources Distributing Centre, Alberta Learning
12360 – 142 Street
Edmonton, AB T5L 4X9
Telephone: (780) 427–5775
Fax: (780) 422–9750
Web site: http://www.lrdc.edc.gov.ab.ca/

Lions-Quest Canada
515 Dotzert Court, Unit 7
Waterloo, ON N2L 6A7
Telephone: 1–800–265–2680
Fax: (519) 725–3118

Mind Resources Inc.
130 Shoemaker Street, Unit 1
Kitchener, ON N2E 3G4
Telephone: (519) 895–0330
Fax: (519) 895–0331
Web site: http://www.mindresources.com

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Web site: http://www.phcanada.com/phg

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Web site: http://www.researchpress.com

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Telephone: 1–800–661–1959
Fax: (780) 451–3958
Web site: http://teachersbooks.epsb.net

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P.O. Box 1056
Gig Harbor, WA 98335
U.S.A.
Telephone: (253) 858–6227
Fax: (253) 853–4960

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SCHIZOPHRENIA

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SCHIZOPHRENIA

The term schizophrenia is used to describe a complex and puzzling condition considered to be the most chronic and disabling of the major mental illnesses. It is a disease caused by multiple factors that affect brain development. It is hypothesized that schizophrenia occurs as a consequence of some combination of genetic factors as well as factors which regulate brain function.

Schizophrenia is an uncommon psychiatric illness in children which is hard to recognize in its early phases. Incidence rates are estimated to be approximately 1 per 10,000 per year.[1] It is most commonly diagnosed in individuals between the ages of 16 and 25. The illness affects males and females with similar frequency. The age of onset tends to be later in females. Although rare, there is a childhood form of the illness that can be diagnosed in preschool children. Symptoms of schizophrenia, such as hallucinations, delusions and incoherence are more difficult to diagnose in children because they are not always able to express themselves well. Children may be unable to recognize or talk about their feelings, mood changes or thoughts. Depending on age and sophistication, they may not realize that their feelings or thoughts, such as hallucinations or delusions, are out of the ordinary. At the same time, it can be hard to disentangle what is seen as normal childhood defiance or moodiness from unusual behaviour changes. It is important to seek medical attention early for two reasons. The first is to determine whether or not the symptoms are caused by some other disease or disorder. The second is that early intervention tends to result in a better outcome.

Due to the complexity of the disorder, few generalizations hold true of all people diagnosed with schizophrenia. Diagnosis is difficult. Generally, it is seen as a disturbance that lasts for at least six months and includes at least one month where two or more symptoms, such as hallucinations, delusions, disorganized speech, grossly disorganized behaviour and other impairments in social functioning exist.

Family, friends and teachers often report the person is not the same, that there has been a change in academic performance or social behaviour. Either the person's characteristic behaviours have lessened or disappeared or they have become excessive and new behaviours have appeared. These symptoms appear in the

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[1] From *Diagnostic and statistical manual of mental disorders* (4th edition) (p. 282), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

person's academic activities, relationships with others, and in personal care and hygiene. For example, an outgoing student may become withdrawn, lose the desire to participate in school events, lose his or her spunk, or show a lack of interest in personal grooming. On the other hand, the student may become "hyper" and excitable, laughing or crying at inappropriate times, may express a new-found zeal for religion or the occult, or become considerably more anxious and worried. Students with schizophrenia have difficulties with attention, memory and planning (Andreasen, 1999).

It has long been known that schizophrenia tends to run in families. Genetic research may reveal a specific genetic marker in the future. Presently, most researchers agree that what may be inherited is a vulnerability or a predisposition to the disorder. This predisposition may be due to a biochemical abnormality, a subtle neurological deficit or some other combination of factors. The close relatives of people with schizophrenia are more likely to develop the disorder than anyone else in the general population. It is not known how the disorder is transmitted and there is no way to accurately predict whether a particular individual will develop the disorder.

Although no biochemical cause has been firmly identified, knowledge of brain chemistry and its link to schizophrenia is growing. Neurotransmitters, the substances that allow communication between nerve cells, are thought to be involved. Treatment currently focuses on reversing or blocking abnormal neural connections.

CHARACTERISTICS AND IDENTIFICATION

Schizophrenia is a difficult disorder to diagnose. Symptoms appear in different configurations and with varying intensity in each individual, and may be confused with other illnesses. A child with schizophrenia may demonstrate behaviours like those of a child with autism, attention difficulties or speech/language difficulties. When symptoms first appear, often in adolescence or early adulthood, they are often more bewildering than serious. Some people have recurring episodes but lead relatively normal lives between episodes. Others may have severe symptoms throughout their lives.

With the onset of severe psychotic symptoms, the person is said to be experiencing acute schizophrenia. Psychotic symptoms refer to a condition where the individual is unable to separate the unreal from the real. Some individuals have only one such episode while others have many episodes throughout their lives. People with chronic schizophrenia generally do not recover normal functioning. Typically, they require long-term treatment and monitoring by a psychiatrist. Treatment usually involves medication to control the symptoms.

Schizophrenia involves a change in behaviour and personality. Recognizing that something is not right and maintaining anecdotal records are important for school personnel. A record of observations can assist with an initial diagnosis as well as with relapses. The student's attending physician and clinic staff usually appreciate the observations of school personnel.

It can be difficult to sort out whether unusual behaviour is related to normal adjustment, the use of drugs or alcohol, delinquency, depression or other psychological difficulties. If school personnel are helping the family with a psychiatric referral, they should find a physician who has an interest in schizophrenia, is additionally specialized, and is prepared to work with the family and school. Other sources for initial assessment and treatment include local mental health services. Contact the nearest Schizophrenia Society or mental health agency for information.

The following behaviours may indicate a student is having difficulty:

- inability to sleep, unusual waking hours, sleeping excessively
- lack of pleasure in activities
- social withdrawal, isolation
- indifference, even in important situations
- lack of sense of humour
- deterioration in social relationships, shutting out friends
- an outgoing student becomes withdrawn, quiet, moody
- dropping out of activities, decline in academic or athletic interests
- hyperactivity or lethargy, or periods of alternation between extremes
- trouble concentrating
- forgetting things, losing valued possessions
- trouble distinguishing dreams or television from reality
- trouble making everyday decisions

- unusual preoccupation with religion or the occult
- unexpected hostility, suspicion, fearfulness; idea that someone is out to get them
- overreaction to disapproval from peers
- deterioration in personal hygiene
- skipping classes or school
- excessive writing without clear meaning, childlike printing
- flat, expressionless gaze
- staring, not blinking or blinking excessively
- unusual sensitivity to light, smells, sounds or textures
- seeing things and hearing voices which are not real
- peculiar use of words or language structure, irrational statements
- bizarre behaviour, such as refusal to touch specific things, wearing excessive or particular clothing, self-mutilation, shaving body hair.

One sign is not enough to indicate the presence of mental illness. It is when several of the behaviours are present, when they represent a change in the student's typical behaviours, when they are persistent, and when they affect the student's ability to function socially and academically that concern should be raised and assistance sought.

Symptoms Which may Underlie Observed Behaviours

Hallucinations

Hallucinations are thought to be the result of sensory sensitivity and of the brain's inability to accurately interpret incoming sensory messages. Students with schizophrenia may hear voices, see things that are not there or experience unusual bodily sensations. For example, the student may find the telephone unbearably loud, have the sensation that something is crawling on his or her skin, or feel no pain from real wounds.

Students may report or respond to auditory, visual, physical, tactile and gustatory (tastable) hallucinations. Auditory hallucinations are the most common perceptual distortion of schizophrenia and are most often experiences as hearing voices that are distinct from the person's thoughts. The content can be variable, with people reporting that the voices tell jokes and make them laugh out loud. Although the voices may be positive, reassuring or neutral, the most common content is threatening, punitive or commanding.

People react and respond to the voices, which explains what may appear to be inappropriate behaviour in particular situations.

Visually, students report distortions in colour, shapes or of faces. For example, a student may be fearful of entering a swimming pool because it seems that his or her leg, dangling in the water (refraction of light) no longer appears joined to the body. The student may report seeing things which do not exist or people who are no longer living.

Delusions
Delusions are fixed, false beliefs. The beliefs remain fixed even with massive evidence to the contrary. Students with delusions may believe that they are being watched, spied on or persecuted. They may believe that their thoughts are being broadcast, that they are receiving messages from aliens or traffic lights, or that specific song lyrics are directed at them. They may believe that they are invulnerable to danger. Students may report that others are talking about them, saying bad things about them or that someone punched them as they were coming down the hall. It is not helpful to argue that these delusions are unreal.

Disordered Perception
Students with schizophrenia may display a disordered perception of reality. They may go to a party where their friends save them a seat, talk to them, joke with them, compliment them, etc., and go home saying that everyone was mean, they wish they hadn't gone and nobody likes them.

This same disordered perception may extend to teacher-student relations. The teacher may be making every allowance possible and every effort to support the student, but the student may come home and say that he or she is yelled at, belittled, unappreciated and disliked by the teacher. It is important that parents and teachers communicate directly.

Thought Disorders
Thought disorders refer to the ways people with schizophrenia process and organize their thoughts. Thoughts or ideas may be slow to form. Thoughts may come extra fast or not at all. Ideas are loosely associated and not connected in a logical manner. Speech may be incoherent. Sounds or rhymes may be substituted for words, or new words are invented. A thought disorder may be accompanied by emotional responses that do not fit the circumstances. Students report that thoughts do not come, that

they get lost or that they simply have no ideas. When ideas do come, they tend to be literal, concrete and set out in black-and-white fashion.

Altered Sense of Self
Students with an altered sense of self appear confused about who they are and where their body is in space. They are unsure if something happened to them or someone else. An altered sense of self can be expressed in clumsiness, reported as a sensation of being without a body or being non-existent.

Lack of Motivation
Lack of motivation is seen as one of the most debilitating aspects of this disorder. Nothing holds any interest or gives pleasure. The student has little energy and can't do much more than sleep and eat. The student does not care about anything, including physical appearance and schoolwork.

Blunted Feelings or Inappropriate Affect
Students with blunted feelings or inappropriate affect show limited or inappropriate facial expressions, gestures and emotional reactions. They may have feelings but are unable to express them. Eye contact is poor and body language reduced. Speech may be monotone. They may grin when anxious or laugh when hurt.

Depression
Depression is more likely to occur when students are feeling better. They may realize the effects this disorder can have on their lives. They may feel they have behaved badly or are unlovable. Depression may lead to talk of or attempts at suicide. This is common and must be taken seriously. Chemical changes in the brain also contribute to depression.

Social Withdrawal
Social withdrawal tends to occur with schizophrenia and can be made worse with depression. Social relationships are overwhelming and withdrawal decreases the stimulation. Withdrawal is not all negative as it does allow the individual to feel more secure. Students with schizophrenia tend not to respond well in group situations or at special occasions when everyone else is excited. This includes special events at school and public holidays, such as Christmas. Social situations can be extremely exhausting and require an extended recovery period.

CHALLENGES FOR FAMILY AND SCHOOL

Finding diagnostic and treatment services can be difficult and time consuming. A first step is to contact the nearest Schizophrenia Society or Mental Health Office listed in the telephone directory. If the student has been diagnosed and is receiving treatment, school personnel should become informed about the disorder so they can better monitor behavioural changes and implement instructional modifications. Staff should also familiarize themselves with current treatment approaches, particularly medications used by students and possible side effects.

There are situations when families need to be convinced to seek medical assistance. If this occurs, knowledge of local services and agencies, as well as documentation of relevant behaviours are important. Be prepared to spend time working with the family.

Be prepared for possible disappointment with the initial visit to the doctor. The student may not demonstrate the behaviours of concern during the appointment with the doctor or referral agency. This illustrates the need for accurate school records over time.

School records should be clear, objective and in point form. List behaviours that could be measured by any other observer present at the time. For example, include changes in the student's attention to grooming, level of participation in school activities or academic work. Provide anecdotal records of bizarre comments and student references to unreal experiences, such as conversations, voices or telephones ringing. Keep artwork that is unusual. Retain copies of all correspondence with agencies or physicians.

When families learn that their children have schizophrenia, their emotional reactions are wide ranging. They report feelings of sorrow, anxiety, isolation, anger, denial and concern for the future. Living with someone with schizophrenia is not easy. Families have to deal with many of the following concerns:

- grief for the "lost" child
- fear of harm to the child or of the child harming someone else
- guilt for having a child with a mental illness
- questioning, "Why our family?"
- feelings of ambivalence
- stress affecting siblings or a spouse because of the attention required by the individual with schizophrenia
- denial of the existence of the disorder
- denial of the severity of the disorder
- additional sources for marital discord

- sleeplessness, particularly when the child is having sleep problems
- changes in social life
- possible increase in the use of prescription drugs or alcohol
- worry for the future of the family
- concern for the future of the child
- searching for community services, coping with bureaucracy
- becoming an advocate
- dealing with professionals who haven't recognized the illness and who blame parents
- general expenses related to the management of the illness.

School personnel should become knowledgeable about the potential effects of this disorder on families. Understanding a family's reactions directly affects the partnership between the school and family. The family is usually the primary support system for the individual with schizophrenia. Families need time to acquire coping strategies, opportunities to gain an understanding of schizophrenia and build a support network.

When in remission, people with schizophrenia may seem relatively unaffected and require minimal social and medical support. Absence of support services during a relapse can be devastating. In some instances, the family may have to request placement in a facility, such as a group home, where around-the-clock supervision can be provided. In other instances, students may need to be hospitalized, particularly when it is difficult to establish optimal dosage levels for prescribed medications to stabilize the illness or to try new medications.

School and family supports for individuals with schizophrenia include access to current information about the disorder and vulnerability to relapse, understanding the need for medical treatment and the role of stress in the ability to manage daily problems. For example, the ramifications of the student's lack of interest or motivation make getting out of bed and to school on time a major effort. Once at school, the student may have little interest in coursework. Even if the motivation is present, some people with schizophrenia struggle with getting words down on paper. Written work often does not measure up to expectations based on previously measured cognitive abilities nor to work done prior to the onset of this disorder.

Professional supports, such as counselling are helpful. Family support groups help families deal with their situation and provide

strategies for coping, such as remaining slightly detached and neutral in interactions with their children. Support groups help alleviate feelings of embarrassment, guilt, frustration, blame and shame.

Problems are likely to be similar at home and school. For instance, dealing with displays of inappropriate affect — inappropriate crying, laughing or becoming upset — are disconcerting and disruptive. Problems with concentration and attention can occur when the student is preoccupied with internal stimuli. Variability in functioning is frustrating to both families and school personnel. Students grasp a concept one day but not the next. They may be able to do the work asked of them tomorrow or later today, but not necessarily.

Measured intellectual abilities may not change but students may have considerable difficulty with schoolwork. They may appear confused and disoriented. There may be problems with long and short-term memory processes. They may not realize that a problem exists and no amount of evidence will change their minds. Odd, stereotyped or ritualized behaviours may appear and affect social interactions. Suicide should be considered a risk factor. Family and school personnel need to be watchful.

Students with schizophrenia may show mild signs of neurological difficulties, such as left/right confusion and poor motor coordination. These factors have implications for participation in sports and physical education classes, handwriting and subject areas requiring visual-motor coordination skills. The situation can be complicated when students experience side effects related to treatment with antipsychotic medications.

Counselling resources, mentors, peer and family supports can be sought through contact with local Schizophrenia Societies or mental health services. School counselling can take the form of assistance with social skills and interpersonal relations using a behavioural approach. Talk therapies are less successful. Peer groups have been shown to have a positive effect on students with schizophrenia, particularly those which spring up naturally, such as when students come regularly to a clinic to have blood work done for medication levels. Experiences are shared and advice is given from peers with personal experience.

Medical and Clinical Treatments

The diagnosis of schizophrenia should only be made by qualified mental health professionals. In cases where schizophrenia is suspected, psychiatrists are generally involved. Teachers can assist by maintaining accurate records and anecdotal notes regarding observations, student interactions, and evidence of student growth, achievement and behaviour. The information included in this resource on medical and clinical treatment of this disorder is intended only to raise the awareness of educational personnel and make them more knowledgeable about therapies that students with emotional disorders or mental illnesses may receive outside school. All medical and clinical therapies must be administered and monitored by qualified mental health professionals.

There is no cure for schizophrenia at present. Treatment usually consists of medication and teaching coping mechanisms on how to live with this chronic illness. In many cases, the individual requires periods of hospitalization. A multidisciplinary approach involving the prescribing physician, school personnel, family and any counsellors, including hospital or clinic staff, is helpful.

Medications

Psychiatrists prescribe a number of medications to help lessen the symptoms of schizophrenia. Newer medications provide effective treatment with fewer side effects. It is important that everyone parenting or working with students with schizophrenia has access to current information about characteristics and side effects of various medications. It is important for the physician or psychiatrist to educate parents and, in turn, parents should be encouraged to inform the school. Physicians and pharmacists can provide information about the effects of various prescription drugs, and often have information sheets which parents can share with the school.

Medical management for individuals requiring medication usually involves systematic trials of one or more medications in different strengths to see which drug or combination of drugs is most effective. Individuals respond differently to different drugs and different doses of the same drug. Each medication differs in how it affects other chemicals in the brain. The length of response time varies enormously. Several months may be needed to see the full therapeutic effects of a particular medication. In individuals who have not yet reached puberty, the margin between symptom relief and side effects is hard to find.

Psychotherapy and Counselling

Through counselling or therapy, knowledgeable professionals can provide support, insight and ways to handle the stresses of living with schizophrenia. They can also provide practical advice about access to community services, vocational support, getting along with others and recognizing signs of relapse. There are a number of psychosocial approaches for individuals and groups, all with a different focus. These include behavioural relearning, social skills training, vocational rehabilitation, cognitive-behaviour therapy, stress management, crisis intervention, self-advocacy and support.

Schizophrenia is sensitive to psychological and social factors. Students and their families require support that is more comprehensive, continuous, long term and involvement intensive than most other chronic medical conditions.

Peer Support and Counselling

Peer support may be obtained through meetings organized by the Schizophrenia Society or Mental Health agencies. Counselling from professionals who understand schizophrenia, which are often hospital or community based, can be a source of support.

SCHOOL STRATEGIES

Concerns in the School Setting

Despite normal measured cognitive abilities, problems with motivation, depression and memory adversely affect the academic progress and social development of students with schizophrenia.

School personnel should familiarize themselves with the disorder by contacting the nearest Schizophrenia Society branch. The resources available through the organization include videos, print materials and information about professional development opportunities. Discussion with the family is strongly recommended and their input into an individualized program plan (IPP) is essential. The student's IPP may include a mix of academic and behavioural goals. More importantly, the IPP should include a list of the adaptations and accommodations required to support achievement of academic and behavioural goals.

Students with schizophrenia vary greatly in their treatment and support needs. It is difficult to say how school supports should be tailored to meet individual needs. The majority of students diagnosed with schizophrenia require modified or adapted programming. Modifications range from a lightened course load

and counselling/therapeutic support to the need for constant supervision, and specialized instructional and behavioural programming.

School personnel need to be aware that most students with schizophrenia improve with medication. Nonetheless, they continue to struggle with difficulties in the areas of attention, concentration, short-term memory, motivation, planning, decision making, experiencing pleasure, having empathy for others and the ability to remain on task for sustained periods of time. In other words, they struggle with the daily routines and skills needed for academic achievement — paying attention in class, getting assignments done, getting along with classmates, remembering their books, retaining the concepts covered in the previous class and other such activities. Some students have a chronic struggle with aspects of self-care, social and vocational skills. Work experience placements and opportunities for employment are affected, particularly during an active phase when, for example, the student may think a supervisor is persecuting him or her or that the headsets worn to take orders from drive-through window patrons are relaying messages from aliens.

The need for a supportive educational environment cannot be overstated. School personnel are urged to be as empathic and supportive as possible. At the same time, school personnel should be aware of their own limitations. They should be able to recognize symptoms of relapse, depression or possible suicide but should not expect to treat them. Parents should be contacted in order to obtain assistance from qualified professionals in the community. School personnel can support the student through structure, predictability and routine in the classes they teach. They can offer a supportive environment and work to enhance the self-esteem of the student. Schools can offer the student access to courses and subject areas which provide the knowledge and skills required to make healthy lifestyle choices. Staff can request specific professional development activities for themselves.

Peers

Peers can be intolerant or supportive. Recognizing that it is difficult to get along with someone who appears unmotivated and apathetic or whose personal hygiene may be poor, school personnel can help students develop attitudes of tolerance and understanding. Perhaps the most supportive peers are those who have had similar experiences and can offer practical advice and understanding.

Relapse

School personnel need to be aware of signs of relapse. These may include many of the initial warning symptoms. Relapse can be triggered by stress, discontinuation of medication, recreational drug use and sometimes for no apparent reason. The most common signs are changes in overall levels of functioning, such as withdrawal from activities, deterioration in personal hygiene or dramatic changes in sleep patterns which may be reported by the family.

Inappropriate Behaviours

Students with schizophrenia are not necessarily aware that their behaviour is inappropriate. Sometimes, a clear, direct statement of how to behave is sufficient. At other times, school personnel may have to deal with bizarre or disturbing behaviour. Difficulties should be anticipated and a management plan developed.

The student may run away when under stress. The school and the family should work out an action plan in advance.

Suicide

The lifetime rate of suicide is high. Risk is greater when individuals are improving or well enough to realize the impact of this chronic illness on their lives. Hallucinations, delusions and the tendency to act impulsively add to the risk.

Contact with Police

As students get older, they may find themselves in trouble with the law. The quality of the social network available to people with schizophrenia makes a substantial difference in reducing the potential for involvement with the legal system. Contact with the police may occur as charges are laid for offences, such as mischief, assaults or theft. These offences may come about during the active phase of the disorder over unusual behaviours, such as impulsive actions, difficulty telling reality from fantasy, bizarre language, irrational and paranoid fears, physical complaints, delusions or identification with other persons, animals or objects. Police may also become involved when a student with schizophrenia engages in such unusual behaviour as hoarding knives in a school locker, preaching on the school steps or hunting enemy frogmen in the river.

Crisis Episode

A crisis episode does not occur without warning signs. However, no one feels fully prepared for the occurrence of a severe break with reality. Schools should be prepared with a list of emergency numbers, including the physician, hospital, family or mobile mental health or crisis unit. An ambulance should be called if the student needs to be transported to a medical facility. Basic crisis intervention training techniques can be implemented to calm the individual. During a crisis situation, it is helpful to have someone the student trusts remain with the student until appropriate intervention can occur or until the student is safely transferred to a hospital. The person should stay with the student until a psychiatrist or doctor can evaluate the student's mental state.

In an extreme situation, when the student is in an altered state of reality and may be responding to something only he or she can see or hear, techniques requiring physical restraint may be required. It is advisable to have an emergency plan for the school. It is strongly recommended that all staff members receive crisis-intervention training sanctioned by the district, coupled with regular refresher courses.

It may be helpful for a mental health professional to conduct a debriefing program with all school staff and students. It is important to understand schizophrenia and not be traumatized by a negative event.

Classroom Strategies to Assist Students with Schizophrenia

School personnel can determine intervention strategies by the outward behaviours of the student, such as memory difficulties, low self-esteem, lack of organizational skills, attention difficulties and poor social skills. The more tailored the interventions are to a particular student, the greater the opportunities for success. It is worth remembering that some strategies are found through a process of elimination and that initial attempts at intervention may be less successful than later ones.

There is a broad range of strategies which teachers may find helpful for students with schizophrenia. Strategies include:

- keep unnecessary visual displays to a minimum
- speak at a slightly slower rate
- keep voice tone low and neutral
- keep instructions short and clear
- retain a predictable timetable and class format

- help the student develop and practise calming and coping strategies, such as relaxation breathing, identifying a safe place to go within the school, a count-to-10 strategy, a reality check with an adult
- provide alternatives, such as walkmans, ear plugs, etc. for auditory difficulties
- be predictable in classroom management
- avoid arguing when encountering a delusional belief, the student cannot be talked out of it
- work to set reasonable goals for academic achievement, particularly after a relapse
- push ahead on a good day, pull back on a bad day
- post classroom rules and refer to them
- set and enforce limits for school conduct (this is a weary task but effective over the long haul for students exhibiting behavioural difficulties)
- encourage participation in extra-curricular activities where the student is likely to experience success
- introduce awareness programs for mental illness with the consent of students and parents
- communicate with the family and, with their permission, the physician. (Some teachers have been encouraged to submit their anecdotal records when the student goes for a check up. Others have been instrumental in providing documentation to support hospital admission, the need for a medication review or to demonstrate progress.)
- model and teach supportive behaviours for all students
- use daily schedules and refer to them
- have the student maintain a written daily schedule
- provide supports and guidance to redirect attention, including physical proximity, visual or auditory cues
- do the first question of an assignment as a demonstration
- set one or two personal goals daily with the student
- use external structure and direction as long as necessary while retaining the long-term goal of personal independence
- remind the student of the task at hand
- encourage the use of self-imposed time away or time out if interpersonal relations are becoming threatening or overwhelming; monitor for signs of stress
- reinforce appropriate behaviours
- accept the student as is.

RESOURCES

This listing is not to be construed as explicit or implicit departmental approval for use of the resources listed. The writers have provided these titles as a service only, to help school authorities identify resources that contain potentially useful ideas. The responsibility to evaluate these resources prior to selection rests with the user, in accordance with any existing local policy.

Resources listed in this section can be ordered from local bookstores and/or publishers/distributors. See page 128 for addresses for publishers/distributors.

Annotated Resources

Children with schizophrenia (1995) by Kevyn Noble & Sandy Lenz. Edmonton, AB: Glenrose Rehabilitation Hospital. ISBN 0–9695567–3–X.

This guide for families and school personnel examines the nature of schizophrenia and the world of the child with schizophrenia. It explains how schizophrenia is diagnosed and offers suggestions for working with health care professionals. Medications and side effects are also discussed. It offers basic coping strategies for parents and looks at the challenges families face. Individual chapters look at effective teaching strategies at school, vocational, educational and leisure issues, and family support groups and resources. The guide also includes diagnostic criteria for schizophrenia and a glossary of related terms.

Schizophrenia: youth's greatest disabler: face it (1997), by Schizophrenia Society of Alberta. Edmonton, AB: Schizophrenia Society of Alberta.

This booklet is an introduction to the basic facts about schizophrenia. It is a compilation of information from a number of acknowledged sources and each section can be used as a separate handout for educational purposes. It outlines causes and symptoms, early warning signs, what it is like to have schizophrenia and how this illness can affect families. The "blame and shame" syndrome is discussed as well as treatments and new developments. There is a short section for educators as well as a list of myths and misconceptions about violence and schizophrenia. Appendices include a list of provincial resources and services, and a glossary of specialized terms.

Surviving schizophrenia: a manual for families, consumers and providers (3rd edition) (1995) by E. Fuller Torrey. New York, NY: HarperCollins. ISBN 0–06–095076–5. Check with your local bookstore.

This manual provides an overview of the frequency and costs of schizophrenia in the United States. It describes how the disease manifests itself through alterations of the senses, inability to interpret and respond, delusions and hallucinations, altered sense of self, and changes in emotion, movements and behaviour. It examines criteria for diagnosis and outlines what schizophrenia is not. It offers predictors of outcome and various theories of the cause of the disease. It looks at the treatment and rehabilitation of people with the disease and identifies six major problems these people face. It also addresses frequently asked questions and offers advice for becoming an effective advocate.

Publisher/Distributor Addresses

Glenrose Rehabilitation Hospital
Education Services
10230 – 111 Avenue
Edmonton, AB T5G 0B7
Telephone: (780) 471–7912
Fax: (780) 471–7924
Web site: http://www.cha.ab.ca/glenrose

Schizophrenia Society of Alberta
Provincial Office
5th Floor, 9942 –108 Street
Edmonton, AB T5K 2J5
Telephone: 1–800–661–4644 (Alberta only) or (780) 427–0579
Fax: (780) 422–2800

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Health and Welfare Canada and the Schizophrenia Society of Canada (1991). *Schizophrenia: a handbook for families*. Ottawa, ON: Health and Welfare Canada.

Kane, J. M. & McGlashan, T. H. (1995). "Treatment of schizophrenia." *The Lancet*, 346, pp. 820–825.

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Thornton, J. F., Seeman, M. V. & Plummer, E. D. (1984). *Schizophrenia: returning home*. Richmond Hill, ON: Merrell Dow Pharmaceuticals (Canada) Inc.

OPPOSITIONAL DEFIANT DISORDER

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OPPOSITIONAL DEFIANT DISORDER

Oppositional defiant disorder is one of the most common psychiatric diagnoses in children (Chandler, 1999), however there is little research regarding this disorder. Children with oppositional defiant disorder are aggressive, lose their tempers easily, and purposefully bother and irritate others. Behaviours associated with oppositional defiant disorder often emerge in the home setting, but over time appear in other settings, such as school and community.[1]

Oppositional defiant disorder is more prevalent in families in which child care is disrupted by a succession of different caregivers, or in families where harsh, inconsistent or neglectful child-rearing practices are common. In preschool years, children, especially boys, may have problematic temperaments, such as difficulty being soothed or high motor activity. In their school years, there may be low self-esteem, moodiness, low frustration tolerance, swearing and the use of alcohol, tobacco or illicit drugs at an unusually early age. There are often conflicts with parents, teachers and peers.[1]

According to *the Diagnostic and Statistical Manual of Mental Disorders* (4th Edition) (DSM-IV), oppositional defiant disorder is defined as a recurrent pattern of negative, defiant, disobedient and hostile behaviour toward authority figures. To be diagnosed with oppositional defiant disorder, the behaviours must occur more frequently than is typically observed in individuals of a comparable age and developmental level, must lead to significant impairment in social, academic or occupational functioning, and usually become evident before age eight and rarely later than early adolescence.[1]

Students with oppositional defiant disorder display disruptive behaviour but of a less severe nature than students diagnosed with conduct disorder.[1] For more on conduct disorder, see the final section of this resource. While oppositional defiant disorder and conduct disorder are strongly and developmentally related, they are clearly different in the severity of the behaviour. Unlike conduct disorder, oppositional defiant disorder typically does not include aggression toward animals or destruction of property. In a significant proportion of cases, oppositional defiant disorder is a developmental antecedent to conduct disorder.[1]

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[1] From *Diagnostic and statistical manual of mental disorders* (4th edition) (pp. 91, 92, 93), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

Students with oppositional defiant disorder display stubborn, negative, hostile and defiant behaviours, without serious violation of the rights of others, as opposed to conduct disorder. Both disorders deal with non-compliance, aggression and hostile behaviour.

CHARACTERISTICS

Students with oppositional defiant disorder display many negative and defiant behaviours. They are moody and easily frustrated. They do not like being told what to do and are full of anger. To fit the criteria of oppositional defiant disorder, the pattern of negative, hostile and defiant behaviour must be demonstrated for no less than six months during which time four or more of the following are present:

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults' requests or rules
- often deliberately annoys people
- often blames others for his or her mistakes or misbehaviours
- often angry and resentful
- often spiteful and vindictive.[2]

(**Note:** Often means daily and weekly occurrences.)

When diagnosing oppositional defiant disorder, the mental health professional examines the child, talks with the child and parents, and reviews medical history. If the individual is attending school, the teacher may be asked to send a report to the mental health professional outlining educational and behavioural concerns. When questioning the family and individual, mental health professionals are assessing the existence, severity and frequency of negative, defiant and disobedient behaviours, hostility, and persistent stubbornness and resistance.

Negative, defiant and disobedient behaviours include:

- arguing
- annoying others
- refusing to comply with requests
- resisting complying with directions
- ignoring classroom and school rules.

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[2] From *Diagnostic and statistical manual of mental disorders* (4th edition) (pp. 93–94), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

Hostility includes:

- anger
- fighting
- verbal aggression
- being resentful of others
- being highly reactive and often unable to control temper
- being spiteful or vindictive
- hurting themselves physically
- swearing and using obscene language.

Persistent stubbornness and resistance include:

- refusing to complete assigned tasks
- blaming others for their mistakes or misbehaviour
- failing to take responsibility for inappropriate actions
- unwillingness to compromise, give in or negotiate with adults and peers
- engaging in power struggles.

CAUSES

The cause of oppositional defiant disorder is unknown. Oppositional defiant disorder usually becomes evident before age eight and usually not later than early adolescence.[3] Many of the behaviours are accepted as normal initially, but do not dissipate with time. Onset is typically gradual, usually occurring over the course of months or years.[4]

Genetic Factors

Oppositional defiant disorder is more common in boys than girls before puberty. This is especially true for those with problematic temperaments in preschool years, such as high reactivity, difficulty being soothed or high motor activity. After puberty, the rates of boys and girls diagnosed with oppositional defiant disorder are more equal.[5] Research indicates that oppositional defiant disorder rarely exists alone; there is usually some other disorder that co-exists with it. The most common disorders are attention deficit disorder, depression and anxiety. It is important to note that in children and adolescents, oppositional behaviour is also a commonly associated feature of mood disorder, psychotic disorder or substance abuse disorder.[6]

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[3] From *Diagnostic and statistical manual of mental disorders* (4th edition) (p. 92), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

[4] Ibid., p. 92.

[5] Ibid., p. 92.

[6] Ibid., p. 93.

Environment and Temperament

Oppositional defiant disorder behaviours may not be evident at school or in the community if structure and routines are in place, and the student perceives the situation to be fair and consistent. Unsupervised time however can be extremely problematic for students with oppositional defiant disorder. When not supervised, rules and expectations are forgotten, and inappropriate choices are made. These students find themselves in negative situations ranging from fighting to shoplifting.

Symptoms of the disorder may be more evident in interactions with adults the student knows well and may not be apparent during clinical examination. Usually, students with this disorder do not regard themselves as oppositional or defiant, but justify their behaviour as a response to unreasonable demands or circumstances.

Students with oppositional defiant behaviour appear angry and resentful. This attitude frequently evokes strong responses in others. These students try to get a reaction out of people and are often successful. They may be good at inciting caregivers or parents to fight with each other to escape scrutiny. This may make some susceptible people believe they can help by giving in to the student. Students with oppositional defiant disorder can set parents against grandparents and teachers against parents. It is common for teachers, parents and sometimes others to be in conflict with each other regarding issues relating to the student. Parents and teachers need to have clear, open lines of communication to avoid negative feelings of blame.

Medical and Clinical Treatments

The diagnosis of oppositional defiant disorder should only be made by qualified mental health professionals. Teachers can assist by maintaining accurate records and anecdotal notes regarding observations, student interactions, and evidence of student growth, achievement and behaviour. The information included in this resource on the medical and clinical treatments of this disorder is intended only to raise the awareness of educational personnel and make them more knowledgeable about therapies that students with emotional disorders or mental illnesses may receive outside school. All medical and clinical therapies must be administered and monitored by qualified mental health professionals.

Students usually benefit most when intervention includes a wide range of strategies, such as behaviour therapy, psychological therapy and medication. Because treatment is difficult, it often

puts stress on those working with students with oppositional defiant disorder.

Behaviour Therapy

Behaviour therapy is often successful in the treatment of oppositional defiant disorder. Parents receive management training, learn how to cope with the individual's tantrums, angry outbursts and argumentative nature, and learn to model appropriate management skills. It also emphasizes how to keep the child with oppositional defiant disorder from playing people against one another. Oppositional defiant disorder is strongly associated with aggression and negative parent-child interactions in childhood. Behavioural therapy helps parents and caregivers lessen the distress they encounter from the continual battle they experience when dealing with individuals with oppositional defiant disorder.

Psychological Therapy

The best forms of treatment for students with oppositional defiant disorder consist of group, individual and/or family therapy. In individual, group or family therapy, a trained professional listens, asks questions and guides the conversation or activities to help individuals with oppositional defiant disorder better understand and cope with their feelings of frustration and anger. Therapy in general is geared toward helping the young person make connections among behaviour, feelings and relationships. The key components of a successful therapeutic approach include offering reassurance, positive reinforcement for effort and providing practical advice. Children with oppositional defiant disorder benefit in the long-term when they are supported in making decisions about their future, such as academic and vocational needs.

Medications

Medications are usually not indicated unless the student has other disorders, such as attention deficit disorder, depression or schizophrenia. If a student is taking medication, the teacher may choose to consult with the parents or physician (with consent) about the characteristics and side effects of the particular medication.

School Strategies

When determining school strategies for students with oppositional defiant disorder, there is a strong correlation between oppositional defiant disorder and conduct disorder. While conduct disorder is more severe in nature, the strategies for addressing inappropriate behaviours in the school setting remain the same.

The educational growth of students with oppositional defiant disorder is best achieved through teamwork. The support and cooperation of families, healthcare practitioners and community agencies involved with the student are essential. At the school level, school administrators, teachers and support staff need to work together to ensure understanding and consistency when dealing with students with oppositional defiant disorder. Planning, communication, teamwork and consistency are keys to success. The following strategies and suggestions will help create the best possible learning environment for students with oppositional defiant disorder.

Administrators

- Establish school-wide expectations for student behaviour.
- Help teachers develop classroom discipline and responsibility plans.
- Develop pre-referral strategies and procedures for early identification and intervention in the area of behaviour.
- Designate a staff person to facilitate the process; i.e., to access resources and services, communicate with parents, enhance collaboration among appropriate agencies, monitor progress and facilitate the team process.
- Be proactive with parents and students — arrange to discuss programming and interventions prior to the first day of instruction. Clearly communicate what can be done in the school setting to support the student with oppositional defiant disorder. Be sensitive regarding expectations about home support and willing to compromise.
- Provide sufficient time for staff to develop an individualized program plan (IPP) and behaviour plan.
- Obtain parental permission to communicate with other professionals working with the student; e.g., family physician, psychiatrist, psychologist.
- Arrange opportunities for teachers to meet individually with the student to discuss behaviour, write plans or contracts and provide constructive feedback regarding behaviour.
- It is important for teachers to be fully aware of all the behaviours and interventions that take place outside the classroom. Develop procedures for school staff to communicate and record problems that occur outside the classroom so that consistent discipline is maintained. Set aside

time to review crisis situations that happen during the day, some of which may have happened outside the classroom. For example, if there is an altercation on the school grounds, the teacher needs to be informed.

- Arrange opportunities and procedures for students to work in alternative settings, such as the library, when difficulties arise during unstructured times, such as recess or noon hour.
- Provide the supports (space, personnel and time) to implement behaviour plans.
- Ensure all staff have the necessary training in collaborative planning, and in the education and behavioural interventions that may be required.

All Staff

- Begin with understanding — all staff working with the student should be knowledgeable about the disorder and its characteristics.
- Remember that the negative behaviour is not personal!
- Be aware of the student's individualized program plan and behaviour plan, and participate in their development when appropriate. It is particularly important that staff know the specific procedures for coping with aggressive and oppositional behaviour.
- Be consistent — school staff should be aware of and apply the strategies. Interventions and consequences (for positive and negative behaviours) should be applied consistently and as soon as possible. Positive behaviours should be reinforced frequently. Negative behaviours should be followed by clearly stated natural consequences applied consistently and immediately.
- Staff working with the student should be trained in non-violent crisis intervention techniques. Physical interventions may be required to ensure the safety of the student and others. (Check with your local school jurisdiction for courses.)
- Celebrate each small step of learning because the student may be behind academically.
- Speak to students privately about their behaviour instead of in front of others, to prevent embarrassment. Public corrections and embarrassment will contribute to the escalation of oppositional behaviour.

- Use humour, especially with older students (but avoid sarcasm).
- Use frequent private corrective feedback, signaling, prompting and cueing strategies.
- Be calm and non-emotional; yelling, threatening, guilt-inducing statements only reduce compliance and escalate oppositional behaviour.
- Know what your own triggers are to avoid being drawn into a negative interaction pattern.

When making requests that the student is required to comply with, the following strategies may increase the chance of success. It is particularly important to include choices.

- Use "start" requests rather than "stop" requests. "Do" requests are more desirable than "don't" requests.
- Use a polite request format; e.g., "Please start your work," rather than, "Isn't it time you do your work?"
- When appropriate, offer a choice; e.g., "Do you want to work at your desk or at the table?"
- Describe the desired behaviour in clear and specific terms to reduce misunderstanding. Avoid entering into a discussion or argument about the behaviour.
- Make one request at a time.
- Make the request in a quiet voice, in close proximity using eye contact.
- It may be necessary to request eye contact before making the request; e.g., "Ben, please look me in the eyes. Now I need you to ..." (Note of caution: In some cultures and ethnic groups, such as Aboriginal cultures, looking someone in the eye may be considered disrespectful.)

Give the student 5 to 10 seconds to respond. The time can vary depending on the situation or the individual. When emotions are heightened, extra time is needed for an individual to process information and change behaviour.

If the student does not comply, the following steps may be necessary.

- Repeat the request or make a new request if needed. Clearly state the student's choices and the resulting consequences. The consequences are pre-planned and are most helpful if they are outlined in a behaviour plan to be followed consistently by all

staff. Providing the student with choices and time to make the choice de-escalates the situation and reduces the potential of a power struggle.

- Make the request twice, then follow through with pre-planned consequences from the classroom discipline and responsibility plan or a specific behaviour plan for an individual. The more often the request is made, the less likely the student will comply.

Parents

Parents may describe their children with oppositional defiant disorder as destructive, willful, defiant and/or aggressive. These children lack social skills, hang out with the wrong crowd and have difficulty learning in school. It is important that all those involved work together. Caring for children with oppositional defiant disorder is stressful, especially if the parent is involved in frequent conflict. Life with a child who has oppositional defiant disorder may be associated with a number of troubling and conflicting feelings for parents. These may include love, anger, anxiety, grief, guilt, fear and depression. These feelings are not unusual, and parents sometimes find it helpful to share their feelings with teachers and support groups. Parents of children with oppositional defiant disorder require support, assistance, patience, energy and determination to remain positive with their children.

The following are ways to support parents of children with oppositional defiant disorder.

- Encourage parents to visit school programs to find one that best meets the needs of their child.
- Encourage parents to have their child visit the school prior to the first day of instruction.
- Encourage parents to actively participate in planning for their child; e.g., participate in developing an individualized program plan and/or behaviour plans for their child.
- Encourage parents to meet with school personnel to review behaviour policies, procedures and expectations of the school program. It is important that parents understand the consequences of misbehaviours and expectations about their role; e.g., picking their child up at school or arranging a back-up plan if they are working and their child needs to be sent home. It is important that school personnel be sensitive to the

individual needs, resources, values, expectations and cultures of families, and prepared to compromise and adjust to individual family circumstances.

- Facilitate communication between home and school by creating a daily logbook that goes back and forth. Explain the importance of communication for teamwork and consistency in the management of their child's behaviour and encourage their participation. Communication will be most effective if one person at the school is responsible for the daily logbook.
- Encourage parents to call the school if they are unsure of what their child is telling them. Be open to the communication and appreciate the opportunity to clarify misconceptions.
- Explain the importance of the parent's support of the school program. Encourage parents to let their child know that they agree with the program and support the school. Again, teamwork and trust between home and school are essential for optimal success.
- Assist parents in setting up an incentive program at home, outlining expectations and rewards, working in conjunction with what the school is doing.
- Help parents establish a structured, consistent and predictable home environment with rules and expectations. This home support enhances the school program and reduces the instances of defiance, non-compliance and aggression in the home. Remember to be sensitive to the culture and values of individual families.
- Encourage parents to be active listeners and take notes to reflect upon later or share with professionals.
- Encourage parents to discover what their child is interested in and arrange activities to enjoy together.
- Encourage parents to work toward preventing some of their child's inappropriate behaviours in the home. Ask them to note what happens before and after the misbehaviour. Do they see a pattern? Can they understand the cause of the misbehaviour? Are there ways they can change the situation to prevent or discourage the misbehaviour?
- Encourage parents to learn as much as they can about the disorder by:
  - talking with mental health or social service professionals who specialize in the disorder

- getting accurate information on the disorder from libraries, hotlines or other sources
- linking with network organizations in the community
- providing them with resources to borrow.

- Encourage parents to follow through with medical or clinical treatments, such as being consistent in administering medications prescribed for their child.

Classroom Strategies

Programming for students with oppositional defiant disorder requires planning and consistency. Key elements include the classroom atmosphere and organization, a classroom discipline and responsibility plan, long-term planning through an individualized program plan and specific behaviour plans to address severely disruptive behaviours.

Organize the Classroom Carefully

- The physical placement of the student with oppositional defiant disorder should be chosen carefully; e.g., who to sit beside, physical distractions, room to move, proximity to the teacher. It is important to avoid choosing a physical location that isolates the student which may make the student less willing and able to interact positively with other students.

- Create pathways for movement. Pathways should eliminate the need to step over objects or between people.

- Consider the space needed to accommodate the student's needs and planned consequences; e.g., quiet corner for working, time-out chair.

- Consider the arrangement of desks to facilitate learning and minimize behaviour problems. Arrangements that facilitate effective behaviour management allow the teacher to move around easily and quickly with access to all students to provide consistent and immediate responses to positive interactions and misbehaviours. Desks in rows allow the teacher to get to each student easily, facilitate student attention and on-task behaviour but may not allow students to work together as well. Desks in groups encourage student interaction and cooperative learning but may make it difficult to maintain student attention during teacher-directed instruction. See *The Teacher's Encyclopedia of Behaviour Management: 100 Problems/500 Plans*, by R. S. Sprick & L. M. Howard.

Organize the Schedule and Instructional Strategies Carefully

- Establish routines and clear expectations for transition times.
- Provide lead-in time for transitions to help students prepare for change.
- Provide positive encouragement prior to situations which are problematic for an individual student; e.g., "It's gym time in 10 minutes. What are you going to do to have a great gym class?" Be sure to follow up after the class and provide positive feedback for appropriate behaviour.
- Plan short and frequent instructional segments with a variety of tasks.
- Provide a clear focus and variety during lessons.
- A change may be needed to reduce conditions which aggravate a student's negative behaviour; e.g., fatigue, hunger, extended periods with lack of movement and sustained attention.
- Provide as much structured choice as possible; e.g., readers' and writers' workshop programs often work well in language arts.

Create an Inviting Classroom

A safe, caring and inviting classroom is important for all students, including students with oppositional defiant disorder.

Teachers need to:

- believe that they make a difference in the lives of students and that all students learn something in their classrooms
- demonstrate respect for students
- be good listeners
- keep in mind that the emotional feel of the classroom is powerful
- avoid singling the student with oppositional defiant disorder out from the rest of the class
- keep a positive tone; humour is great but sarcasm is hurtful
- keep suggestions for improvement constructive and specific
- avoid over-generalizing, using words like "always" and "never"
- be specific in providing feedback about when, where, how and why, either behaviour or academic work needs to improve
- listen to concerns of students and let them know you are available to discuss them
- send a regular newsletter home informing parents of current themes, curriculum content, behavioural expectations and academic successes

- scan the room frequently to monitor behaviour, particularly appropriate behaviour to be reinforced
- actively monitor the class with low-key interventions, such as proximity and eye contact — proximity also provides opportunities to reward appropriate behaviour with a nod, smile, or hand on the shoulder
- develop routines or rituals that are conducive to learning. "Rituals are activities repeated in the classroom to create a desired emotion or mindset in the learner and communicate: 'what's important here.' . . . How the teacher deals with homework, grades, attendance, discipline, questions, humour, etc., are examples of rituals" (Phillips, 1992).

  Some examples are:
  - greet students at the door
  - conduct getting-to-know-you activities at the beginning of the year
  - have students work together to create classroom rules or mission statements
  - reinforce rules by reviewing them with students and, when necessary, reminding them of how well they work.

Develop a Classroom Discipline and Responsibility Plan

The classroom discipline and responsibility plan provides clear guidelines and expectations for all students. Students will know which behaviours are appropriate, which are not and the consequences for inappropriate behaviour. This plan enables the teacher to respond consistently to the behaviours of all students in the classroom and is a necessary starting point for effective management of the behaviour of students with oppositional defiant behaviour. The ideas presented below are adapted from *The Teacher's Encyclopedia of Behaviour Management: 100 Problems/500 Plans*, by R. S. Sprick and L. M. Howard.

Communicate clear expectations for student behaviour.

- Use classroom rules effectively to clearly communicate expectations to all students. Rules are most effective if:
  - students are involved in writing them
  - the number is limited
  - they are written in positive terms
  - they are posted
  - they are referred to and reviewed on an ongoing basis.

For more information, see *Teaching for Student Differences*, Book 1 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, page TSD.113.

Emphasize and acknowledge appropriate behaviour.

- Rewarding good behaviour is more effective than punishing negative behaviour. Catch the student demonstrating appropriate behaviour and provide positive reinforcement, such as verbal praise, nonverbal approval, privileges, activities, feedback to parents, written feedback to the student.
- Descriptive praise helps students understand how they behaved appropriately and increases the chances that the behaviour will be repeated. Instead of saying, "terrific job," say, "I noticed you worked on your own for 10 minutes," or "When you needed help, you raised your hand and waited quietly for me," or "You used your words to solve a problem with Joe."
- For the student with oppositional defiant disorder, it is particularly important to reward compliance. If students are not rewarded, compliance will decrease. Initially, external reinforcement is important. Hopefully, external supports can be faded as the student develops greater internal self-control.

There are a variety of responses to misbehaviours. It is important to identify the type of misbehaviour and the appropriate consequence, and to consistently apply the planned consequences for all students.

- Verbal reprimands and opportunities to practise appropriate behaviour are given when it appears a student is not aware that he or she is engaging in inappropriate behaviour; e.g., laughing inappropriately. Corrective feedback is given along with instruction that encourages positive practise of an alternative behaviour.
- Deliberately ignoring the student is appropriate for misbehaviours that do not interfere with students' learning, are not dangerous, and which may be reinforced by attention; e.g., tapping a pencil, making snide comments or disgusting noises. Alternatively, desired behaviours should be given positive attention.
- In-class consequences are required for minor misbehaviours that cannot be ignored; e.g., poking other students, tearing up papers. Consequences should be logically associated with the

inappropriate behaviour; e.g., staying in at recess or after school to redo work, in-class time out, contacting the student's parent, changing seat assignment.

- Out-of-class consequences are required for severely disruptive behaviour; e.g., yelling obscenities, continuous arguing, defying the teacher, and aggressive and dangerous behaviour. It may be useful to develop a specific behaviour plan to address persistent severely disruptive behaviours. Such a plan maximizes efficiency, consistency and safety.
- It may be helpful to make a specific written agreement or behaviour contract to target a short-term objective for a particular student. For more information about behaviour contracts, see *Teaching for Student Differences*, Book 1 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, page TSD.46.

Develop an Individualized Program Plan (IPP)

An IPP is a written commitment of intent by an educational team to ensure the provision of appropriate programming for students with special needs. The IPP focuses on improving student outcomes — improved academic functioning and improved behavioural functioning. It is developed through a team approach involving parents, teachers, administrators and other professionals working with the student. The IPP should be a meaningful working document in which modifications to programming to meet the needs of students are outlined and progress is recorded. Each student is different and may respond differently to strategies. The IPP considers an individual student's strengths, likes, dislikes and interests; academic, social and behavioural needs; and responses to strategies.

An IPP should be developed when the teacher's regular instructional strategies or behavioural guidelines are not effective in helping students achieve or function at an age or grade appropriate level. Many students with oppositional defiant disorder function below grade level, sometimes due to additional learning or attention difficulties and sometimes as a result of the negative effects their inappropriate behaviour has had on their learning, particularly through missed instruction time.

The student with oppositional defiant disorder needs to learn appropriate behaviours. The IPP provides a process to identify the desired behaviours, plan strategies to help the student learn these behaviours and determine who will be responsible for

implementing the strategies. The process is most effective when parents, other professionals and community agencies are actively involved with school personnel to develop and implement the IPP. For example, community partners may be actively involved in teaching social skills or anger management. The tracking form presented on page 12 may be helpful in promoting teamwork to address the needs of students with oppositional defiant disorder.

Take a strength-based focus to the development of IPPs. Avoid focusing on the student's inappropriate behaviour but rather focus on desirable replacement behaviours; e.g., "What do I want the student to do instead? What's the best way to help him or her reach these goals?"

The behaviour goals identify desired behaviours, for example:

- will respond constructively to adult feedback and correction (for a student who argues or responds with anger)
- will use appropriate exclamations (for a student who swears)
- will respond maturely to teasing (for a sensitive or aggressive student)
- will calm down without aggressive acts, or identify problem situations and respond appropriately (for an aggressive student)
- will complete tasks in a timely manner (for a student who doesn't get started or stay on task)
- will work cooperatively with other students (for a student who makes fun of others).

The team should prioritize the goals. There may be many areas of need but only a few should be selected to work on first. Progress is monitored and new goals set.

Suggested areas to consider include the following.

- Teach relaxation techniques, such as deep breathing to help the student deal with anger.
- Teach recognition of physical signals of anger or distress; e.g., increased heart rate.
- Teach self-monitoring. Students who observe and track what they do become more aware of their problem behaviour and/or improvements. Self-monitoring helps students with mild misbehaviour or habitual behaviour; e.g., blurting out, complaining, off-task behaviour, careless work, poor listening skills, making inappropriate comments or poor social skills. For more information, see *Teaching Students with Learning*

Disabilities, Book 6 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, pages LD.212–215.

- Teach social skills. For more information, see *Teaching for Student Differences*, Book 1 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, pages TSD.5–11, 68–77; *Teaching Students with Learning Disabilities*, Book 6 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, pages LD.209–211.
- Teach coping strategies to deal with anxiety and stress.
- Teach problem solving.

A behaviour contract or structured reinforcement program may be developed to target a specific short-term objective under a long-term goal in the IPP. Such contracts can help a student become more aware of the target behaviour. The contract should ensure that the student will experience some level of immediate success. Behaviour contracts are short-term strategies.

It is important to include a plan for communication between home and school; e.g., a communication book that goes home on a daily basis describing the student's day and homework to be completed. A system of rewards and consequences may be specified to ensure the student carries the book back and forth.

A plan for communication with other professionals involved in supporting the student will contribute to positive teamwork.

Ongoing anecdotal notes are important for monitoring changes in behaviour, the effectiveness or ineffectiveness of strategies, and interventions and new difficulties to be addressed.

Develop a Behaviour Plan

The term "behaviour plan" refers to a range of informal and formal procedures for addressing inappropriate behaviour. For students with oppositional defiant disorder, a formal behaviour plan may be necessary to address severely disruptive behaviours which require out-of-class consequences. The plan is designed to reduce classroom disruptions and must be used along with long-range plans to help the student develop appropriate behaviours outlined in an IPP.

Steps and components to a behaviour plan include the following.[7]

- Gather background information.
- Contact the student's parent (discuss the problem, arrange for a conference and collaborative problem solving).
- Meet with appropriate staff members to design procedures (everyone needs to know how to respond).
- Identify positive student behaviour, minor misbehaviour (doesn't prevent teacher from teaching) and severe misbehaviour (prevents teaching).
- Establish procedures to focus on appropriate student behaviour and strengths.
- Arrange in-class consequences for minor misbehaviour; e.g., ignore pencil tapping; in-class time out for poking others; repair or replace property destroyed.
- Arrange out-of-class consequences for severe misbehaviour.

When a student does not comply with requests to stop a severe misbehaviour, there should be specific steps and agreed upon procedures.[8]

- Give the student the choice of going to a specified location on his or her own or with assistance; e.g., someone to accompany him or her. The choice for students to go on their own may not always be appropriate.
- Contact the office or other personnel and get help to remove the student. It is important to have back-up plans for getting the assistance of another adult; e.g., Who will help if the designated person is out of the building? It is extremely important that all personnel involved have training and practice in non-violent crisis intervention.
- Redirect the other students. Prepare the class for crisis situations so that there is a routine to follow during intervention with a specific student.
- Arrange supervision during out-of-class time in a specified location. Set up the space for out-of-class time carefully. It should not be interesting or reinforcing in any way. A school-wide reciprocal supervision program may be appropriate to ensure adequate supervision. For example, excluded students are placed in a designated classroom where they may be

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[7] Adapted from *The Teacher's encyclopedia of behavior management: 100 problems/500 plans* (pp. 323–326, 328–331) by R. S. Sprick & L. M. Howard, 1995, Longmont, CO: Sopris West Inc. Adapted with permission.

required to write an incident report or complete assigned work. The student must be held accountable for time and work missed while out of the classroom.

- Plan for transition back into the classroom. The procedure for transitioning back into the classroom should include how long the student will be out of the classroom and identify who will discuss the student's behaviour to help the student recognize the inappropriate behaviour and plan to behave differently in the future. For more information on behaviour interviews see *Teaching for Student Differences*, Book 1 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, pages TSD.117–118. The behaviour interview may involve completing an incident report. The student writes up the incident, taking ownership for his or her actions. Questions include:
  – What did I do to get here?
  – What will I do the next time I am in a similar situation?
  – What do I need to do right now to solve the problem?
  The incident report is dated and signed by the student, teacher and possibly the parents.
- Set up a record-keeping and evaluation system.
- Discuss problem behaviours and the behaviour plan with the student.
- Role play the procedure with staff (and the student if possible) prior to a situation where additional assistance is needed. This component is essential to help identify unanticipated difficulties, develop contingency plans and promote staff confidence in carrying out the plan. Remember that teamwork and consistency are keys to success. If the classroom teacher is not confident that assistance will be provided, he or she may not follow through consistently on agreed upon consequences for severe misbehaviour.

The effectiveness of the behaviour plan must be reviewed. It is expected that the frequency of severe misbehaviours will decrease. However, if severe misbehaviour persists, the effectiveness of the behaviour plan and the strategies in the IPP need to be reviewed to determine factors influencing the behaviour. Are the interventions described in the IPP leading to positive behaviour change? Does the student have the opportunity to learn alternative behaviours? Is there a need for further support and different interventions? What changes are needed?

Entire page adapted from *The Teacher's encyclopedia of behavior management: 100 problems/500 plans* (pp. 323–326, 328–331) by R. S. Sprick & L. M. Howard, 1995, Longmont, CO: Sopris West Inc. Adapted with permission.

Other Students

It is important for all students to feel school is a safe and caring place, even in the presence of those with oppositional defiant disorder. This usually means constant supervision is required and instructing other students in the class is necessary. The following strategies and suggestions will help other students interact positively with their peers with oppositional defiant disorder.

- Have students learn the classroom routines and appropriate behaviour required when the teacher is occupied with the student with oppositional defiant disorder.
- Reward and reinforce the class when they are helpful and follow routines.
- Explain to students the importance of walking away from possible confrontation which may lead to aggression.
- Teach students to ignore the student with oppositional defiant behaviour when he or she is behaving inappropriately.
- Encourage students to get help as soon as they feel the situation is getting out of control.
- When doing group work, strategically place the student with oppositional defiant disorder with others who model appropriate behaviour. It may be helpful to have the student with oppositional defiant disorder buddy up with a positive role model he or she respects.
- Encourage all students to be a positive part of the classroom team and join in school activities.
- Use peer teaching and role modeling to encourage appropriate behaviour.
- Encourage peers to reinforce, prompt, remind and support positive behaviour of each other, and in particular of the student with oppositional defiant disorder.
- Discourage students from wearing hats or jackets in class. It reduces the possibility of students hiding toys, sharp objects or other inappropriate paraphernalia in their clothing.

RESOURCES

This listing is not to be construed as explicit or implicit departmental approval for use of the resources listed. The writers have provided these titles as a service only, to help school authorities identify resources that contain potentially useful ideas. The responsibility to evaluate these resources prior to selection rests with the user, in accordance with any existing local policy.

Resources listed in this section can be ordered from local bookstores and/or publishers/distributors. See pages 159–160 for addresses for publishers/distributors.

Print Resources

Administrative intervention: a school administrator's guide to working with aggressive and disruptive students (1993) by Donald D. Black & John C. Downs. Longmont, CO: Sopris West Inc. ISBN 0–944584–57–8. Grades 6–12.

This handbook for school administrators outlines strategies for dealing effectively with students who are aggressive and disruptive. It offers suggestions for de-escalation and outlines a model of information gathering and on-the-spot social skill training that could include how to follow instructions, how to accept criticism or a consequence, how to accept "No" for an answer, how to make a request, how to get the teacher's attention or how to greet someone. Subsequent chapters include student apologies, behaviour contracting and in-school suspensions. The summary includes a short discussion of special cases and six rules for an administrative intervention.

Back off, cool down, try again: teaching students how to control aggressive behavior (1995) by Sylvia Rockwell. Reston, VA: The Council for Exceptional Children. ISBN 0–86586–263–X.

This book uses classroom dynamics to help students move through the developmental stages of social interaction. The author offers teaching procedures for social skill instruction and increasing student self-awareness, self-control, self-reliance and self-esteem. The focus moves from teacher control to control through peer interaction. The resource presents practical strategies for group management; affective and academic instruction; and planning, documentation and consultation. The appendices include a list of affective and academic instructional resources, reinforcement activities, behaviour management forms, planning forms and examples of themed instructional units.

Best practices — behavioral and educational strategies for teachers (1997) by H. Kenton Reavis, Stevan J. Kukic, William R. Jenson, Daniel P. Morgan, Debra J. Andrews, & Susan L. Fister (eds.). Longmont, CO: Sopris West Inc. ISBN 1–57035–052–3. Grades 1–12.

Based on a program developed by the Utah State Office of Education, *Best Practices* offers teachers condensed descriptions and outlines of 12 educational practices. Through techniques such as over-correction, contracts, home notes, group contingencies, peer tutoring and time out, teachers can improve students' motivation, cooperative learning, academic performance and behaviour within the classroom. This resource also includes reproducible tools and handouts for implementing the strategies.

Classroom management: a thinking and caring approach (1994) by Barrie Bennett & Peter Smilanich. Toronto, ON: Bookation Inc. and Edmonton, AB: Perceptions. ISBN 0–9695388–1–2. Available from the Teachers' Book Depository.

The authors discuss the complexity of school discipline and analyze what effective and not-so-effective teachers do. The authors link unsatisfied needs with misbehaviour and outline steps for preventing misbehaviour by creating environments where students belong. The role of instructional skills, cooperative learning and conflict-resolution techniques are discussed, as well as ways to start the school year. Final chapters deal with handling misbehaviours through low-key responses, squaring off, giving choices, defusing power struggles, informal agreements and formal contracts. The process and pitfalls of establishing school-wide discipline policies are discussed, as well as recent research on effective schools.

Esteem builders: a K–8 self esteem curriculum for improving student behavior and school climate (1989) by Michelle Borba. Rolling Hills Estate, CA: Jalmar Press. ISBN 0–915190–53–2. ECS–Grade 8. Available from the Teachers' Book Depository.

An ECS–Grade 8 program that uses five building blocks of self-esteem (security, selfhood, affiliation, mission, competence) as a base. Includes over 250 grade-level, curriculum-content, cross-related activities, assessment tools and a checklist of educator behaviours for modelling. Contains instantly usable award designs for certificates, buttons and posters, a 40-week lesson planner and extensive bibliography.

Helping kids handle anger: teaching self control (1988) by Pat Huggins & Judy Williams. Longmont, CO: Sopris West Inc. ISBN 0–944584–96–9. Grades 1–6.

This manual is a guide for teaching elementary students social skills. Each field-tested lesson includes background theory, a script, practice activities, transparency masters and reproducible worksheets, and supplementary activities. Lessons include recognizing anger as a normal feeling, using self-talk, expressing anger in an assertive, socially acceptable manner, four steps for controlling anger, dealing with frustration, directing anger appropriately, using "I-messages," responding to a peer's anger, accepting criticisms and handling put-downs. The appendices include art and writing activities, additional teacher resource materials, and pretests and post-tests on lesson concepts.

Room 14: a social language program (1993) by Carolyn C. Wilson. East Moline, IL: LinguiSystems, Inc. ISBN 1–55999–255–7. Grades 1–5.

Room 14, for ages 6–10, includes an activity book, instructor's manual and picture book. It is a curriculum resource which integrates easily into a language arts program with stories, comprehension questions and activities for making and keeping friends, fitting in at school, handling feelings, using self-control and being responsible. Lessons are well-organized and well-planned.

Skillstreaming the elementary school child: new strategies and perspectives for teaching prosocial skills (1997) by Ellen McGinnis & Arnold P. Goldstein. Champaign, IL: Research Press Company/Colwell Systems. ISBN 0–87822–372–X. Grades 1–6. Available from the Learning Resources Distributing Centre.

This resource addresses social skill deficiency and its remediation through the prosocial skills training approach called Skillstreaming. The curriculum is divided into five skill groups: classroom survival skills, friendship-making skills, skills for dealing with feelings, alternatives to aggression and skills for dealing with stress. Within each skill group, strategies are provided for teaching elementary school children 60 specific prosocial skills; e.g., asking for help, saying thank you, using self-control, accepting consequences, making a complaint, dealing with group pressure.

The Teacher's encyclopedia of behavior management: 100 problems/500 plans (1995) by Randall S. Sprick & Lisa M. Howard. Longmont, CO: Sopris West Inc. ISBN 1–57035–031–0. ECS–Grade 9.

This reference book contains approximately 100 common classroom problems arranged alphabetically by title. Each problem includes general considerations, model plans, and suggested steps for developing and implementing a plan. The appendices deal with three topics: reinforcing appropriate behaviour, assigning responsibilities or jobs and responding to inappropriate behaviour. An index includes multiple descriptive titles for each problem.

Teaching for student differences (1995), Book 1 of the *Programming for Students with Special Needs* series by the Special Education Branch of Alberta Education. Edmonton, AB: Alberta Education. ISBN 0–7732–1834–3. ECS–Grade 12. Available from the Learning Resources Distributing Centre.

Highlights strategies for differentiating instruction within the regular classroom for students who may be experiencing learning or behavioural difficulties, or who may be gifted and talented. It also describes a process for modifying the regular program and includes forms to assist in teacher planning.

Teaching students with learning disabilities (1996), Book 6 of the *Programming for Students with Special Needs* series by the Special Education Branch of Alberta Education. Edmonton, AB: Alberta Education. ISBN 0–7732–1799–1. ECS–Grade 12. Available from the Learning Resources Distributing Centre.

This resource provides practical strategies for regular classroom and special education teachers. Section one discusses the conceptual model and applications for the domain model. Section two includes identification and program planning, addressing early identification, assessment, learning styles and long-range planning. Section three contains practical strategies within specific domains, including metacognitive, information processing, communication, academic and social/adaptive. Section four addresses other learning difficulties, including attention-deficit/hyperactivity disorder and fetal alcohol syndrome/possible prenatal alcohol-related effects. The appendices contain lists of annotated resources, test inventories, support network contacts and blackline masters.

The Tough kid book: practical classroom management strategies (1993) by Ginger Rhode, William R. Jenson & H. Kenton Reavis. Longmont, CO: Sopris West Inc. ISBN 0–944584–54–3. Grades 1–8.

The Tough Kid Book gives teachers practical techniques to be used with students who are difficult. These techniques can be implemented inexpensively and quickly. The book is divided into four chapters. The first identifies what a "tough kid" looks like. It covers the realistic assessment of students who are difficult and proactive methods of setting up a classroom. The second chapter focuses on interventions to reward students for coming to school, following classroom procedures and performing academically. The third chapter reviews realistic techniques to help teachers stop problem behaviours. The last chapter includes more advanced techniques, including social skills training materials, instructional techniques, programs to improve on-task behaviour and parent training information.

The Tough kid tool box (1994) by William R. Jenson, Ginger Rhode & H. Kenton Reavis. Longmont, CO: Sopris West Inc. ISBN 1–57035–000–0. Grades 1–8.

This resource complements and supplements *The Tough Kid Book* by providing in-depth explanations and techniques that teachers can use in everyday situations. The sections include:

- mystery motivators (incentive systems designed to deliver random rewards for appropriate behaviours)
- home note program (informational note that goes from classroom to home, and back to school)
- self-monitoring program (a process in which students observe and collect data on their own behaviours)
- behaviour contracting (involves placing contingencies for reinforcement into a written document which is agreed to and signed by all parties)
- tracking procedures (monitoring students' behaviours and academic performance)
- unique reinforcers (positive reinforcement is given to students immediately after desired behaviours occur)
- general interventions (variety of interventions with detailed instructions for use).

Each section begins with a definition of the intervention, a specific description of the intervention and complete steps for implementing the technique. Trouble-shooting suggestions and

"making it even better" suggestions are offered as well. The purchasing teacher has permission to reproduce the tools for use in the classroom.

Video Resources

Anger: you can handle it (1996) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. Grades 7–12.

This video for high school students follows several teenagers as they experience and discuss anger. The video looks at anger triggers and anger styles — ways in which people express their anger, and ways to take positive action. It emphasizes that regardless of what makes us angry, we are always responsible for our own actions. The video presents a three-step process: cool off, assess the situation and take constructive action. This resource also includes a teacher's guide.

I Can make good choices (1995) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. Grades 2–4.

Children learn the steps involved in making a decision: understanding the options, predicting the outcomes and living with the consequences. The teacher's guide provides guidelines and questions for classroom discussion, suggested related activities and instructions for using the accompanying activity sheets. This resource could be useful for small groups or for the whole class. This resource includes a 17-minute video, student worksheets and a teacher's guide.

I Get so mad (1993) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. ECS–Grade 2.

When young children get angry, their strong feelings can propel them into inappropriate or destructive behaviour. *I Get So Mad* makes students aware that anger is a natural emotion that everyone experiences at times. It helps them understand that it is not the "getting mad" that matters, but rather what they decide to do about it, that counts. This program offers children easy-to-understand ways of coping with anger. Includes a 13-minute video, student worksheets, audiocassette and teacher's guide.

Solving conflicts — student workshop (1994) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. Grades 2–5.

This kit is designed as a hands-on workshop. The video presents scenarios and focuses on the skills of getting the facts, listening, expressing feelings and brainstorming. Since conflict resolution is often difficult to achieve, the techniques shown are not guaranteed to work. This resource should be used with other materials that portray people with disabilities and Aboriginal people solving conflicts. Other components include a teacher's guide and student worksheets.

Straight talk II: violent times (1996) by Attainment Company, Inc. Verona, WI: Attainment Company, Inc. Grades 7–12. Available from Sunburst Communications.

This series is the sequel to the popular award-winning video series *Straight Talk*. *Straight Talk: Violent Times* features the frank testimonials of 13 teens who have been exposed to violence in their daily lives. Some are perpetrators, some are victims and some, witnesses. Many were victimized early in life and acted out violently themselves as they entered their teens. Now they are learning to cope with their past and prepare for a more positive future. The series includes three, 25-minute videotapes: *A Time of Rage*, *A Time of Grief* and *A Time for Healing*. This resource includes a discussion guide.

Ten things to do instead of hitting (1995) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. ECS–Grade 2.

Targeted at children in ECS–Grade 2, this video features four short, realistic vignettes and music videos that show children dealing with angry feelings that have been triggered by a variety of situations. The goal of this video is to help children recognize, name and deal with emotions, and build a repertoire of acceptable alternatives that allow them to defuse anger and hostility without resorting to aggression. Other components include an audiocassette, a teacher's guide and student worksheets.

What to do about anger — student workshop (1997) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. Grades 2–4.

What To Do About Anger is designed as a hands-on workshop in anger management skills. The premise is to help children get along better with friends, family and adults. The program teaches children the difference between angry feelings and angry behaviours, how to handle anger by controlling how they act, and how to deal with angry energy in a safe and positive way. Includes a 16-minute video, student worksheets and teacher's guide.

When anger turns to rage (1995) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. Grades 5–9.

This video is addressed to upper elementary and junior high students. It examines anger from the student's point-of-view, using real-life circumstances. It introduces a variety of practical anger management skills young people can use in day-to-day situations. It shows students that there are safe, nondestructive ways of expressing and dealing with this complex human emotion. The video also stresses that anger can be a powerful way of motivating people to seek positive change and that students can channel their anger to achieve constructive goals. Includes a 27-minute video and teacher's guide.

When you're mad, mad, mad! (1993) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. Grades 5–9.

For middle school students, the loss of control that anger provokes is alarming and can undermine their self-esteem. This video helps students understand that anger is normal, and helps them differentiate between angry feelings and angry behaviours. It shows students how they can handle anger and control how they act. It also suggests positive steps to take. This resource includes a teacher's guide.

Student Resources

Canadian Mental Health Association
#328, 9707 – 110 Street
Edmonton, AB T5K 2L9
Telephone: (780) 482–6576
Web site: http://www.mentalhealth.com

Publisher/Distributor Addresses

Council for Exceptional Children
1920 Association Drive
Reston, VA 20191–1589
U.S.A.
Telephone: 1–888–232–7733 or (703) 620–3660
Fax: (703) 264–9494
Web site: http://www.cec.sped.org/index.html

Learning Resources Distributing Centre, Alberta Learning
12360 – 142 Street
Edmonton, AB T5L 4X9
Telephone: (780) 427–5775
Fax: (780) 422–9750
Web site: http://www.lrdc.edc.gov.ab.ca/

LinguiSystems, Inc.
3100 – 4th Avenue
East Moline, IL 61244–9700
U.S.A.
Telephone: 1–800–PRO IDEA (776–4332) or (309) 755–2300
Fax: 1–800–577–4555 or (309) 755–2377
Web site: http://www.linguisystems.com

Sopris West Inc.
Longmont, CO
Canadian Distributor:
The Teachers' Book Depository
18004 – 116 Avenue
Edmonton, AB T5S 1L5
Telephone: 1–800–661–1959
Fax: (780) 451–3958
Web site: http://teachersbooks.epsb.net

Sunburst Communications
(Canadian Branch)
P.O. Box 1150, Station A
Windsor, ON N9A 9Z9
Telephone: 1–800–431–1934
Fax: (519) 966–6701

The Teachers' Book Depository
18004 – 116 Avenue
Edmonton, AB T5S 1L5
Telephone: 1–800–661–1959
Fax: (780) 451–3958
Web site: http://teachersbooks.epsb.net

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CONDUCT DISORDER

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CONDUCT DISORDER

Conduct disorder is defined as a repetitive and persistent pattern of behaviour in which the basic rights of others, or major age-appropriate societal norms or rules are violated. Conduct disorder causes significant impairment in both social and academic functioning, and the behaviour pattern is usually present in a variety of settings, such as home, school and community.[1] Conduct disorder usually involves severe behaviour that often results in the involvement of law enforcement agencies. The behaviour, although similar, is of a more serious nature than oppositional defiant disorder.

Conduct disorder is diagnosed in severity as mild, moderate or severe.[2]

Mild — Few if any conduct problems in excess of those required to make the diagnosis are present, and the conduct problems cause relatively minor harm to others; e.g., lying, truancy, staying out after dark without permission.

Moderate — The number of conduct problems and the effect on others are between mild and severe; e.g., stealing but not confronting a victim, vandalism.

Severe — Many conduct problems in excess of those required to make the diagnosis are present, or the conduct problems cause considerable harm to others; e.g., forced sex, physical cruelty, use of weapons, stealing while confronting a victim, breaking and entering.

Students with conduct disorder often initiate aggressive behaviour and react aggressively to others. They have little empathy and concern for the feelings, wishes and well-being of others. They often have low self-esteem, may come from chaotic or unsettled home lives and may be dealing with other issues, such as depression, learning difficulties, and alcohol or substance abuse.

Because these students have difficulty with authority figures and do not trust easily, they can be difficult to work with. It is important that proper interventions and treatments be in place. Caregivers, teachers and community members often experience frustration when dealing with students with conduct disorder. It

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[1] From *Diagnostic and statistical manual of mental disorders* (4th edition) (p. 85), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

[2] Ibid., p. 87.

takes extreme patience and care to work with these students. Progress is often slow. Students with conduct disorder require a highly structured environment and routine to function effectively.

There is a correlation between conduct disorder and oppositional defiant disorder. Students with conduct disorder generally exhibit more severe forms of chronic behaviour than students with oppositional defiant disorder.

Many young children with oppositional defiant disorder later develop conduct disorder. In one study, virtually all clinic-referred youths with prepubertal onset of conduct disorder retained the symptoms of oppositional defiant disorder that emerged at earlier ages (Lahey et al., 1992). Conduct disorder is rarely diagnosed before age six.[3]

Individuals with conduct disorder must exhibit three or more of the specific criteria within the past 12 months, with at least one symptom being present in the past six months.

These criteria fall under four categories:

- aggression to people and animals
- destruction of property
- deceit or theft
- serious violation of rules.[4]

CHARACTERISTICS

Students with conduct disorder display many antisocial behaviours, often find themselves confronted by the law, and feel little guilt or remorse for their actions. Their behaviours are more severe than ordinary childish or adolescent rebelliousness. To fit the criteria of conduct disorder, the pattern of behaviours must be demonstrated for no less than six months. As the student grows older, the behaviour becomes more serious, although many of the following characteristics may be found in children as early as age six.

Aggressive behaviour includes:[5]

- often bullying, threatening or intimidating others

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[3] From *Diagnostic and statistical manual of mental disorders* (4th edition) (p. 89), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

[4] Ibid., p. 85.

[5] Some points taken from *Diagnostic and statistical manual of mental disorders* (4th edition) (pp. 86, 87), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

- often initiating physical fights
- using weapons that can cause serious physical harm to others; e.g., bat, brick, broken bottle, knife or gun
- being physically cruel to people
- being physically cruel to animals.

Deceitfulness or theft includes:[5]

- stealing from others; e.g., bicycles, lunches, money, toys
- breaking promises
- lying to avoid punishment or obligations
- cheating in games and school work
- letting peers take the blame for his or her inappropriate behaviour
- shoplifting
- forgery
- lying to obtain goods and favours, or avoid obligations, such as conning others
- feeling little remorse or guilt.

Serious violation of rules includes:[5]

- often staying out late at night despite parental prohibitions; beginning before age 13
- often being truant from school; beginning before age 13
- early onset of smoking, drinking, use of illegal drugs, sexual activity and other reckless, risk-taking acts
- deliberate destruction of property at school, in the home or neighbourhood
- stealing while confronting a victim, such as mugging, purse snatching, extortion or armed robbery
- forcing someone into sexual activity
- running away from home at least twice, or once without returning for a lengthy period.

Significant impairment in social and academic functioning includes:

- refusal to cooperate
- social immaturity
- low self-esteem although "acts tough"
- failing grades on report cards
- disregard for home and school rules
- functioning below grade level academically
- frequent or numerous suspensions or expulsions from school
- deficiency in basic social and self-management skills.

Onset of the Disorder

There are two subtypes of conduct disorder — childhood onset and adolescent onset.

Childhood-onset Type

Childhood-onset type is defined by the onset of at least one characteristic of conduct disorder, as listed on pages 165–166, prior to age 10. There are usually frequent displays of physical aggression toward others and disturbed peer relations. These students may have had oppositional defiant disorder prior to age 10 and now have symptoms that meet all the criteria for conduct disorder prior to puberty.[6]

Adolescent-onset Type

Adolescent-onset type is defined by the absence of any criteria for conduct disorder prior to age 10. These students have had a normal early history, without any conduct disorder characteristics appearing in early childhood. The good news is these children are less likely to have persistent conduct disorder in adulthood and appear to have a more positive prognosis for the future.[6]

Causes

Several factors play a role in the disorder. Researchers continue to investigate genetic and environmental factors that may contribute to the development of conduct disorder in children and adolescents.

Genetic Factors

Children may inherit a vulnerability to the disorder. Evidence suggests there is a genetic link. Children with parents who display antisocial behaviours tend to develop the same problems (American Psychiatric Association, 1992). Research indicates heredity probably influences certain personality traits, such as risk taking. Genetic factors are usually not enough on their own to cause conduct disorder. Other factors, such as attention deficit disorder or chaotic and unsettled home lives have a contributing role in the negative and inappropriate behaviours displayed by students with conduct disorder.

Many students with conduct disorder have other disorders. Common disorders that co-exist in students with conduct disorder are fetal alcohol syndrome, substance-related disorders and attention deficit disorder. These disorders not only interfere with

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[6] From *Diagnostic and statistical manual of mental disorders* (4th edition) (pp. 86, 87), by the American Psychiatric Association, 1994, Washington, DC: American Psychiatric Association. Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Copyright 1994 American Psychiatric Association.

the student's relationship with peers and family, but with academic success as well.

Conduct disorder may be a defense against anxiety (American Psychiatric Association, 1992). If the student has difficulty coping in a setting such as school and is behind academically, it may be easier to act out and be removed from class than to stay and participate in the lesson. There may have been a lack of nurturing or bonding with the parent after birth due to drug or alcohol dependency, or a failure to internalize controls (American Psychiatric Association, 1992). Consequences, limits and society norms have little meaning.

Environmental Factors

Some theories suggest these students are trying to cope with hostile, chaotic environments and inconsistent parenting, or trying to gain social status among their peers. Family stresses, such as divorce and domestic violence may be contributing factors. Children who live with inconsistent rules, harsh discipline, poverty, neglect and sexual or physical abuse, or who associate with delinquent friends and lack supervision are more likely to develop conduct disorder. Children who observe others obtaining rewards for inappropriate behaviours may imitate these behaviours. The imitating of inappropriate behaviours may prevent the development of positive prosocial attitudes and behaviours. It should be noted drug and alcohol abuse in children tends to be a consequence rather than a cause of conduct disorder.

Children and adolescents with the most severe and violent conduct disorders often have mental disabilities, are neurologically impaired, epileptic or have sustained head injuries. In these cases, the students are a danger to themselves and others. Because of brain damage, these children have difficulty understanding cause and effect relationships. This results in limited comprehension of the law and the potential for frequent infractions. Consequently, they require constant supervision, and are a challenge to parent and educate.

Teachers often experience difficulty educating these students academically and socially. A variety of treatments are needed to help the child, and all those around the child, cope with the disorder.

MEDICAL AND CLINICAL TREATMENTS

The diagnosis of conduct disorder should only be made by qualified mental health professionals. Teachers can assist by maintaining accurate records and anecdotal notes regarding observations, student interactions, and evidence of student growth, achievement and behaviour. The information included in this resource on the medical and clinical treatments of this disorder is intended only to raise the awareness of educational personnel and make them more knowledgeable about therapies that students with emotional disorders or mental illnesses may receive outside school. All medical and clinical therapies must be administered and monitored by qualified mental health professionals .

Conduct disorder is one of the more difficult disorders to treat. Students usually benefit most when there is a wide range of intervention, such as psychological therapy, behaviour therapy and, in some cases, medication. Because treatment is difficult, it often challenges those who work with students with conduct disorder.

Children with adolescent-onset type may naturally outgrow their delinquent behaviours. Those with childhood-onset type are more likely to continue demonstrating characteristics of conduct disorder into adulthood. Those who abuse drugs and alcohol are more difficult to treat.[7] Successful treatment depends, in part, on early diagnosis and the resolution of certain contributing factors, such as chaotic or unsettled home lives. Treatment is long term, especially if the home environment is less than ideal. School is sometimes the only safe and consistent environment these students have. In school, the rules are consistent and fair. The student knows the consequences of inappropriate behaviour and is rewarded for appropriate behaviour. When working with students with conduct disorder, a team approach works best. This is where the family, community and mental health professionals all work together.

This includes:

- education about the disorder
- individual and family therapy
- parental training
- social skills training
- behaviour modification
- remedial educational programming
- substance abuse counselling
- residential or day treatment facilities
- encouragement to stay in school.

[7] From "What is conduct disorder?" prepared by the Alberta Mental Health Board, Forensic Psychiatry Services, Turning Point Program, Edmonton, AB: Alberta Mental Health Board. Taken from web site [http://ahe.pmhab.ab.ca/~foren/turningpoint/conduct.htm]. Reprinted with permission.

Although it is the parents' choice to share information with the school, they should be encouraged to do so to ensure a collaborative team approach and the best possible learning environment for their children.

Psychological Therapy

Treatment for students with conduct disorder is controversial. These students are often difficult to engage in treatment and may have trouble tolerating the intensity of individual therapy. Any therapy must include helping individuals with conduct disorder better understand and accept responsibility for their behaviour. Therapy in general is geared toward helping the young person make connections among behaviour, feelings and relationships.

The key components of a successful therapeutic approach include offering reassurance, positive reinforcement for effort and providing practical advice. Children with oppositional defiant disorder benefit in the long-term when they are supported in making decisions about their future, such as academic and vocational needs.

Family therapy may include developing problem-solving skills for both parents and students, encouraging parents to acknowledge and reward appropriate behaviour, and helping them establish and enforce reasonable limits. Helping families develop negotiating skills and the ability to compromise are often important components.

Group therapy encourages exploration of feelings and self-control over behaviour. It can help students develop social skills, self-esteem and confidence.

Behaviour Therapy

Behaviour therapy is an approach that uses rewards and consequences to shape behaviour. Teachers have used tokens and rewards in the classroom to reinforce appropriate behaviours. This method of changing inappropriate habits and responses is often successful in a specific environment and when consistently applied. However, it has been found that once a program has concluded, the positive gains are not maintained nor do they generalize to other settings. This is particularly evident if a student demonstrates a wide range of difficult inappropriate behaviours.

Students with conduct disorder have difficulty internalizing rules and transferring them from one setting to another. Educators may find a discrepancy between how the student gets along at school compared to at home.

Students with conduct disorder function best when their environment is predictable and consistent. Stable, predictable environments provide students with sufficient time to think, and increase their chances and opportunities to make positive choices. It is more difficult to establish and maintain such a highly structured environment in home and community settings. Students may not make the same positive choices they make in the school environment. This also happens in reverse, where students have more difficulty at school than at home.

Students with conduct disorder eventually need to be able to move to self-management. This includes setting personal goals, identifying triggers and situations which increase personal anxiety, talking about feelings rather than acting upon them, developing and maintaining a predictable daily schedule, learning communication and social skills, and establishing acceptable limits of behaviour.

Medications

Medications are usually not indicated unless the student has other disorders, such as attention deficit disorder, depression or schizophrenia. If a student is taking medication, the teacher may choose to consult with the parents or physician (with consent) about the characteristics and side-effects of the particular medication. It should be noted that drug therapy should not be used as a substitute for other treatments or to allow the student to disclaim responsibility for his or her actions.

SCHOOL STRATEGIES

When determining school strategies for students with conduct disorder, there is a strong correlation between oppositional defiant disorder and conduct disorder. While conduct disorder is more severe in nature, the strategies for addressing inappropriate behaviours in the school setting remain the same.

The educational growth of students with conduct disorder is best achieved through teamwork. The support and cooperation of families, healthcare practitioners and community agencies involved with the student are essential. At the school level, school administrators, teachers and support staff need to work together to ensure understanding and consistency when dealing with students

with conduct disorder. Planning, communication, teamwork and consistency are keys to success. The following strategies and suggestions will help create the best possible learning environment for students with conduct disorder.

Administrators

- Establish school-wide expectations for student behaviour.
- Help teachers develop classroom discipline and responsibility plans.
- Develop pre-referral strategies and procedures for early identification and intervention in the area of behaviour.
- Designate a staff person to facilitate the process; i.e., to access resources and services, communicate with parents, enhance collaboration among appropriate agencies, monitor progress and facilitate the team process.
- Be proactive with parents and students — arrange to discuss programming and interventions prior to the first day of instruction. Clearly communicate what can be done in the school setting to support the student with conduct disorder. Be sensitive regarding expectations about home support and willing to compromise.
- Provide sufficient time for staff to develop an individualized program plan (IPP) and behaviour plan.
- Obtain parental permission to communicate with other professionals working with the student; e.g., family physician, psychiatrist, psychologist.
- Arrange opportunities for teachers to meet individually with the student to discuss behaviour, write plans or contracts and provide constructive feedback regarding behaviour.
- It is important for teachers to be fully aware of all the behaviours and interventions that take place outside the classroom. Develop procedures for school staff to communicate and record problems that occur outside the classroom so that consistent discipline is maintained. Set aside time to review crisis situations that happen during the day, some of which may have happened outside the classroom. For example, if there is an altercation on the school grounds, the teacher needs to be informed.

- Arrange opportunities and procedures for students to work in alternative settings, such as the library, when difficulties arise during unstructured times, such as recess or noon hour.
- Provide the supports (space, personnel and time) to implement behaviour plans.
- Ensure all staff have the necessary training in collaborative planning, and in the education and behavioural interventions that may be required.

All Staff

- Begin with understanding — all staff working with the student should be knowledgeable about the disorder and its characteristics.
- Remember that the negative behaviour is not personal!
- Be aware of the student's individualized program plan and behaviour plan, and participate in their development when appropriate. It is particularly important that staff know the specific procedures for coping with aggressive and oppositional behaviour.
- Be consistent — school staff should be aware of and apply the strategies. Interventions and consequences (for positive and negative behaviours) should be applied consistently and as soon as possible. Positive behaviours should be reinforced frequently. Negative behaviours should be followed by clearly stated natural consequences applied consistently and immediately.
- Staff working with the student should be trained in non-violent crisis intervention techniques. Physical interventions may be required to ensure the safety of the student and others. (Check with your local school jurisdiction for courses.)
- Celebrate each small step of learning because the student may be behind academically.
- Speak to students privately about their behaviour instead of in front of others, to prevent embarrassment. Public corrections and embarrassment will contribute to the escalation of oppositional behaviour.
- Use humour, especially with older students (but avoid sarcasm).
- Use frequent private corrective feedback, signaling, prompting and cueing strategies.

- Be calm and non-emotional; yelling, threatening, guilt-inducing statements only reduce compliance and escalate oppositional behaviour.
- Know what your own triggers are to avoid being drawn into a negative interaction pattern.

When making requests that the student is required to comply with, the following strategies may increase the chance of success. It is particularly important to include choices.

- Use "start" requests rather than "stop" requests. "Do" requests are more desirable than "don't" requests.
- Use a polite request format; e.g., "Please start your work," rather than, "Isn't it time you do your work?"
- When appropriate, offer a choice; e.g., "Do you want to work at your desk or at the table?"
- Describe the desired behaviour in clear and specific terms to reduce misunderstanding. Avoid entering into a discussion or argument about the behaviour.
- Make one request at a time.
- Make the request in a quiet voice, in close proximity using eye contact.
- It may be necessary to request eye contact before making the request; e.g., "Ben, please look me in the eyes. Now I need you to ..." (Note of caution: In some cultures and ethnic groups, such as Aboriginal cultures, looking someone in the eye may be considered disrespectful.)

Give the student 5 to 10 seconds to respond. The time can vary depending on the situation or the individual. When emotions are heightened, extra time is needed for an individual to process information and change behaviour.

If the student does not comply, the following steps may be necessary.

- Repeat the request or make a new request if needed. Clearly state the student's choices and the resulting consequences. The consequences are pre-planned and are most helpful if they are outlined in a behaviour plan to be followed consistently by all staff. Providing the student with choices and time to make the choice de-escalates the situation and reduces the potential of a power struggle.

- Make the request twice, then follow through with pre-planned consequences from the classroom discipline and responsibility plan or a specific behaviour plan for an individual. The more often the request is made, the less likely the student will comply.

Parents

Parents may describe their children with conduct disorder as destructive, willful, defiant and/or aggressive. These children lack social skills, hang out with the wrong crowd and have difficulty learning in school. It is important that all those involved work together. Caring for children with conduct disorder is stressful, especially if the parent is involved in frequent conflict. Life with a child who has conduct disorder may be associated with a number of troubling and conflicting feelings for parents. These may include love, anger, anxiety, grief, guilt, fear and depression. These feelings are not unusual, and parents sometimes find it helpful to share their feelings with teachers and support groups. Parents of children with conduct disorder require support, assistance, patience, energy and determination to remain positive with their children.

The following are ways to support parents of children with conduct disorder.

- Encourage parents to visit school programs to find one that best meets the needs of their child.
- Encourage parents to have their child visit the school prior to the first day of instruction.
- Encourage parents to actively participate in planning for their child; e.g., participate in developing an individualized program plan and/or behaviour plans for their child.
- Encourage parents to meet with school personnel to review behaviour policies, procedures and expectations of the school program. It is important that parents understand the consequences of misbehaviours and expectations about their role; e.g., picking their child up at school or arranging a back-up plan if they are working and their child needs to be sent home. It is important that school personnel be sensitive to the individual needs, resources, values, expectations and cultures of families, and prepared to compromise and adjust to individual family circumstances.

- Facilitate communication between home and school by creating a daily logbook that goes back and forth. Explain the importance of communication for teamwork and consistency in the management of their child's behaviour and encourage their participation. Communication will be most effective if one person at the school is responsible for the daily logbook.
- Encourage parents to call the school if they are unsure of what their child is telling them. Be open to the communication and appreciate the opportunity to clarify misconceptions.
- Explain the importance of the parent's support of the school program. Encourage parents to let their child know that they agree with the program and support the school. Again, teamwork and trust between home and school are essential for optimal success.
- Assist parents in setting up an incentive program at home, outlining expectations and rewards, working in conjunction with what the school is doing.
- Help parents establish a structured, consistent and predictable home environment with rules and expectations. This home support enhances the school program and reduces the instances of defiance, non-compliance and aggression in the home. Remember to be sensitive to the culture and values of individual families.
- Encourage parents to be active listeners and take notes to reflect upon later or share with professionals.
- Encourage parents to discover what their child is interested in and arrange activities to enjoy together.
- Encourage parents to work toward preventing some of their child's inappropriate behaviours in the home. Ask them to note what happens before and after the misbehaviour. Do they see a pattern? Can they understand the cause of the misbehaviour? Are there ways they can change the situation to prevent or discourage the misbehaviour?
- Encourage parents to learn as much as they can about the disorder by:
  - talking with mental health or social service professionals who specialize in the disorder
  - getting accurate information on the disorder from libraries, hotlines or other sources
  - linking with network organizations in the community
  - providing them with resources to borrow.

- Encourage parents to follow through with medical or clinical treatments, such as being consistent in administering medications prescribed for their child.

Classroom Strategies

Programming for students with conduct disorder requires planning and consistency. Key elements include the classroom atmosphere and organization, a classroom discipline and responsibility plan, long-term planning through an individualized program plan and specific behaviour plans to address severely disruptive behaviours.

Organize the Classroom Carefully

- The physical placement of the student with conduct disorder should be chosen carefully; e.g., who to sit beside, physical distractions, room to move, proximity to the teacher. It is important to avoid choosing a physical location that isolates the student which may make the student less willing and able to interact positively with other students.
- Create pathways for movement. Pathways should eliminate the need to step over objects or between people.
- Consider the space needed to accommodate the student's needs and planned consequences; e.g., quiet corner for working, time-out chair.
- Consider the arrangement of desks to facilitate learning and minimize behaviour problems. Arrangements that facilitate effective behaviour management allow the teacher to move around easily and quickly with access to all students to provide consistent and immediate responses to positive interactions and misbehaviours. Desks in rows allow the teacher to get to each student easily, facilitate student attention and on-task behaviour but may not allow students to work together as well. Desks in groups encourage student interaction and cooperative learning but may make it difficult to maintain student attention during teacher-directed instruction. See *The Teacher's Encyclopedia of Behaviour Management: 100 Problems/500 Plans*, by R. S. Sprick & L. M. Howard.

Organize the Schedule and Instructional Strategies Carefully

- Establish routines and clear expectations for transition times.
- Provide lead-in time for transitions to help students prepare for change.

- Provide positive encouragement prior to situations which are problematic for an individual student; e.g., "It's gym time in 10 minutes. What are you going to do to have a great gym class?" Be sure to follow up after the class and provide positive feedback for appropriate behaviour.
- Plan short and frequent instructional segments with a variety of tasks.
- Provide a clear focus and variety during lessons.
- A change may be needed to reduce conditions which aggravate a student's negative behaviour; e.g., fatigue, hunger, extended periods with lack of movement and sustained attention.
- Provide as much structured choice as possible; e.g., readers' and writers' workshop programs often work well in language arts.

Create an Inviting Classroom

A safe, caring and inviting classroom is important for all students, including students with conduct disorder.

Teachers need to:

- believe that they make a difference in the lives of students and that all students learn something in their classrooms
- demonstrate respect for students
- be good listeners
- keep in mind that the emotional feel of the classroom is powerful
- avoid singling the student with conduct disorder out from the rest of the class
- keep a positive tone; humour is great but sarcasm is hurtful
- keep suggestions for improvement constructive and specific
- avoid over-generalizing, using words like "always" and "never"
- be specific in providing feedback about when, where, how and why, either behaviour or academic work needs to improve
- listen to concerns of students and let them know you are available to discuss them
- send a regular newsletter home informing parents of current themes, curriculum content, behavioural expectations and academic successes
- scan the room frequently to monitor behaviour, particularly appropriate behaviour to be reinforced

- actively monitor the class with low-key interventions, such as proximity and eye contact — proximity also provides opportunities to reward appropriate behaviour with a nod, smile, or hand on the shoulder
- develop routines or rituals that are conducive to learning. "Rituals are activities repeated in the classroom to create a desired emotion or mindset in the learner and communicate: 'what's important here?' . . . How the teacher deals with homework, grades, attendance, discipline, questions, humour, etc., are examples of rituals" (Phillips, 1992).

  Some examples are:
  - greet students at the door
  - conduct getting-to-know-you activities at the beginning of the year
  - have students work together to create classroom rules or mission statements
  - reinforce rules by reviewing them with students and, when necessary, reminding them of how well they work.

Develop a Classroom Discipline and Responsibility Plan

The classroom discipline and responsibility plan provides clear guidelines and expectations for all students. Students will know which behaviours are appropriate, which are not and the consequences for inappropriate behaviour. This plan enables the teacher to respond consistently to the behaviours of all students in the classroom and is a necessary starting point for effective management of the behaviour of students with conduct behaviour. The ideas presented below are adapted *from The Teacher's Encyclopedia of Behaviour Management: 100 Problems/500 Plans*, by R. S. Sprick and L. M. Howard.

Communicate clear expectations for student behaviour.

- Use classroom rules effectively to clearly communicate expectations to all students. Rules are most effective if:
  - students are involved in writing them
  - the number is limited
  - they are written in positive terms
  - they are posted
  - they are referred to and reviewed on an ongoing basis.

For more information, see *Teaching for Student Differences*, Book 1 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, page TSD.113.

Emphasize and acknowledge appropriate behaviour.

- Rewarding good behaviour is more effective than punishing negative behaviour. Catch the student demonstrating appropriate behaviour and provide positive reinforcement, such as verbal praise, nonverbal approval, privileges, activities, feedback to parents, written feedback to the student.
- Descriptive praise helps students understand how they behaved appropriately and increases the chances that the behaviour will be repeated. Instead of saying, "terrific job," say, "I noticed you worked on your own for 10 minutes," or "When you needed help, you raised your hand and waited quietly for me," or "You used your words to solve a problem with Joe."
- For the student with conduct disorder, it is particularly important to reward compliance. If students are not rewarded, compliance will decrease. Initially, external reinforcement is important. Hopefully, external supports can be faded as the student develops greater internal self-control.

There are a variety of responses to misbehaviours. It is important to identify the type of misbehaviour and the appropriate consequence, and to consistently apply the planned consequences for all students.

- Verbal reprimands and opportunities to practise appropriate behaviour are given when it appears a student is not aware that he or she is engaging in inappropriate behaviour; e.g., laughing inappropriately. Corrective feedback is given along with instruction that encourages positive practise of an alternative behaviour.
- Deliberately ignoring the student is appropriate for misbehaviours that do not interfere with students' learning, are not dangerous, and which may be reinforced by attention; e.g., tapping a pencil, making snide comments or disgusting noises. Alternatively, desired behaviours should be given positive attention.
- In-class consequences are required for minor misbehaviours that cannot be ignored; e.g., poking other students, tearing up papers. Consequences should be logically associated with the inappropriate behaviour; e.g., staying in at recess or after school to redo work, in-class time out, contacting the student's parent, changing seat assignment.
- Out-of-class consequences are required for severely disruptive behaviour; e.g., yelling obscenities, continuous arguing, defying

the teacher, and aggressive and dangerous behaviour. It may be useful to develop a specific behaviour plan to address persistent severely disruptive behaviours. Such a plan maximizes efficiency, consistency and safety.

- It may be helpful to make a specific written agreement or behaviour contract to target a short-term objective for a particular student. For more information about behaviour contracts, see *Teaching for Student Differences*, Book 1 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, page TSD.46.

Develop an Individualized Program Plan (IPP)

An IPP is a written commitment of intent by an educational team to ensure the provision of appropriate programming for students with special needs. The IPP focuses on improving student outcomes — improved academic functioning and improved behavioural functioning. It is developed through a team approach involving parents, teachers, administrators and other professionals working with the student. The IPP should be a meaningful working document in which modifications to programming to meet the needs of students are outlined and progress is recorded. Each student is different and may respond differently to strategies. The IPP considers an individual student's strengths, likes, dislikes and interests; academic, social and behavioural needs; and responses to strategies.

An IPP should be developed when the teacher's regular instructional strategies or behavioural guidelines are not effective in helping students achieve or function at an age or grade appropriate level. Many students with conduct disorder function below grade level, sometimes due to additional learning or attention difficulties and sometimes as a result of the negative effects their inappropriate behaviour has had on their learning, particularly through missed instruction time.

The student with conduct disorder needs to learn appropriate behaviours. The IPP provides a process to identify the desired behaviours, plan strategies to help the student learn these behaviours and determine who will be responsible for implementing the strategies. The process is most effective when parents, other professionals and community agencies are actively involved with school personnel to develop and implement the IPP. For example, community partners may be actively involved in

teaching social skills or anger management. The tracking form presented on page 12 may be helpful in promoting teamwork to address the needs of students with conduct disorder.

Take a strength-based focus to the development of IPPs. Avoid focusing on the student's inappropriate behaviour but rather focus on desirable replacement behaviours; e.g., "What do I want the student to do instead? What's the best way to help him or her reach these goals?"

The behaviour goals identify desired behaviours, for example:

- will respond constructively to adult feedback and correction (for a student who argues or responds with anger)
- will use appropriate exclamations (for a student who swears)
- will respond maturely to teasing (for a sensitive or aggressive student)
- will calm down without aggressive acts, or identify problem situations and respond appropriately (for an aggressive student)
- will complete tasks in a timely manner (for a student who doesn't get started or stay on task)
- will work cooperatively with other students (for a student who makes fun of others).

The team should prioritize the goals. There may be many areas of need but only a few should be selected to work on first. Progress is monitored and new goals set.

Suggested areas to consider include the following.

- Teach relaxation techniques, such as deep breathing to help the student deal with anger.
- Teach recognition of physical signals of anger or distress; e.g., increased heart rate.
- Teach self-monitoring. Students who observe and track what they do become more aware of their problem behaviour and/or improvements. Self-monitoring helps students with mild misbehaviour or habitual behaviour; e.g., blurting out, complaining, off-task behaviour, careless work, poor listening skills, making inappropriate comments or poor social skills. For more information, see *Teaching Students with Learning Disabilities*, Book 6 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, pages LD.212–215.

- Teach social skills. For more information, see *Teaching for Student Differences*, Book 1 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, pages TSD.5–11, 68–77; *Teaching Students with Learning Disabilities*, Book 6 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, pages LD.209–211.
- Teach coping strategies to deal with anxiety and stress.
- Teach problem solving.

A behaviour contract or structured reinforcement program may be developed to target a specific short-term objective under a long-term goal in the IPP. Such contracts can help a student become more aware of the target behaviour. The contract should ensure that the student will experience some level of immediate success. Behaviour contracts are short-term strategies.

It is important to include a plan for communication between home and school; e.g., a communication book that goes home on a daily basis describing the student's day and homework to be completed. A system of rewards and consequences may be specified to ensure the student carries the book back and forth.

A plan for communication with other professionals involved in supporting the student will contribute to positive teamwork.

Ongoing anecdotal notes are important for monitoring changes in behaviour, the effectiveness or ineffectiveness of strategies, and interventions and new difficulties to be addressed.

Develop a Behaviour Plan

The term "behaviour plan" refers to a range of informal and formal procedures for addressing inappropriate behaviour. For students with conduct disorder, a formal behaviour plan may be necessary to address severely disruptive behaviours which require out-of-class consequences. The plan is designed to reduce classroom disruptions and must be used along with long-range plans to help the student develop appropriate behaviours outlined in an IPP.

Steps and components to a behaviour plan include the following.[8]

- Gather background information.
- Contact the student's parent (discuss the problem, arrange for a conference and collaborative problem solving).
- Meet with appropriate staff members to design procedures (everyone needs to know how to respond).
- Identify positive student behaviour, minor misbehaviour (doesn't prevent teacher from teaching) and severe misbehaviour (prevents teaching).
- Establish procedures to focus on appropriate student behaviour and strengths.
- Arrange in-class consequences for minor misbehaviour; e.g., ignore pencil tapping; in-class time out for poking others; repair or replace property destroyed.
- Arrange out-of-class consequences for severe misbehaviour.

When a student does not comply with requests to stop a severe misbehaviour, there should be specific steps and agreed upon procedures.[8]

- Give the student the choice of going to a specified location on his or her own or with assistance; e.g., someone to accompany him or her. The choice for students to go on their own may not always be appropriate.
- Contact the office or other personnel and get help to remove the student. It is important to have back-up plans for getting the assistance of another adult; e.g., Who will help if the designated person is out of the building? It is extremely important that all personnel involved have training and practice in non-violent crisis intervention.
- Redirect the other students. Prepare the class for crisis situations so that there is a routine to follow during intervention with a specific student.
- Arrange supervision during out-of-class time in a specified location. Set up the space for out-of-class time carefully. It should not be interesting or reinforcing in any way. A school-wide reciprocal supervision program may be appropriate to ensure adequate supervision. For example, excluded students are placed in a designated classroom where they may be

[8] Adapted from *The Teacher's encyclopedia of behavior management: 100 problems/500 plans* (pp. 323–326, 328–331) by R. S. Sprick & L. M. Howard, 1995, Longmont, CO: Sopris West Inc. Adapted with permission.

required to write an incident report or complete assigned work. The student must be held accountable for time and work missed while out of the classroom.

- Plan for transition back into the classroom. The procedure for transitioning back into the classroom should include how long the student will be out of the classroom and identify who will discuss the student's behaviour to help the student recognize the inappropriate behaviour and plan to behave differently in the future. For more information on behaviour interviews see *Teaching for Student Differences*, Book 1 of the *Programming for Students with Special Needs* series, by the Special Education Branch of Alberta Education, pages TSD.117–118. The behaviour interview may involve completing an incident report. The student writes up the incident, taking ownership for his or her actions. Questions include:
  – What did I do to get here?
  – What will I do the next time I am in a similar situation?
  – What do I need to do right now to solve the problem?
  The incident report is dated and signed by the student, teacher and possibly the parents.
- Set up a record-keeping and evaluation system.
- Discuss problem behaviours and the behaviour plan with the student.
- Role play the procedure with staff (and the student if possible) prior to a situation where additional assistance is needed. This component is essential to help identify unanticipated difficulties, develop contingency plans and promote staff confidence in carrying out the plan. Remember that teamwork and consistency are keys to success. If the classroom teacher is not confident that assistance will be provided, he or she may not follow through consistently on agreed upon consequences for severe misbehaviour.

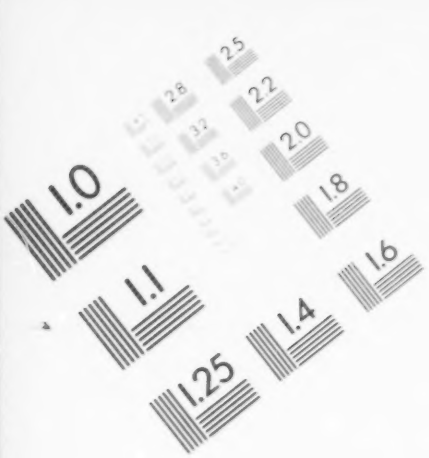
The effectiveness of the behaviour plan must be reviewed. It is expected that the frequency of severe misbehaviours will decrease. However, if severe misbehaviour persists, the effectiveness of the behaviour plan and the strategies in the IPP need to be reviewed to determine factors influencing the behaviour. Are the interventions described in the IPP leading to positive behaviour change? Does the student have the opportunity to learn alternative behaviours? Is there a need for further support and different interventions? What changes are needed?

Entire page adapted from *The Teacher's encyclopedia of behavior management: 100 problems/500 plans* (pp. 323–326, 328–331) by R. S. Sprick & L. M. Howard, 1995, Longmont, CO: Sopris West Inc. Adapted with permission.

Other Students

It is important for all students to feel school is a safe and caring place, even in the presence of those with conduct disorder. This usually means constant supervision is required and instructing other students in the class is necessary. The following strategies and suggestions will help other students interact positively with their peers with conduct disorder.

- Have students learn the classroom routines and appropriate behaviour required when the teacher is occupied with the student with conduct disorder.
- Reward and reinforce the class when they are helpful and follow routines.
- Explain to students the importance of walking away from possible confrontation which may lead to aggression.
- Teach students to ignore the student with conduct disorder when he or she is behaving inappropriately.
- Encourage students to get help as soon as they feel the situation is getting out of control.
- When doing group work, strategically place the student with conduct disorder with others who model appropriate behaviour. It may be helpful to have the student with conduct disorder buddy up with a positive role model he or she respects.
- Encourage all students to be a positive part of the classroom team and join in school activities.
- Use peer teaching and role modeling to encourage appropriate behaviour.
- Encourage peers to reinforce, prompt, remind and support positive behaviour of each other, and in particular of the student with conduct disorder.
- Discourage students from wearing hats or jackets in class. It reduces the possibility of students hiding toys, sharp objects or other inappropriate paraphernalia in their clothing.



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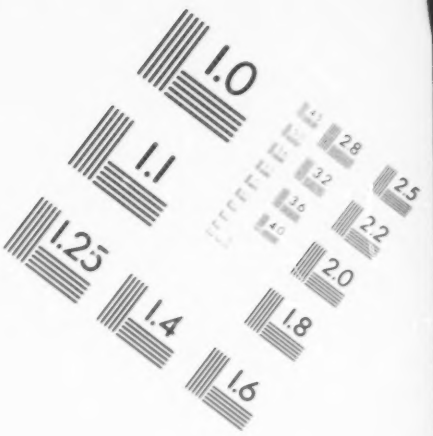

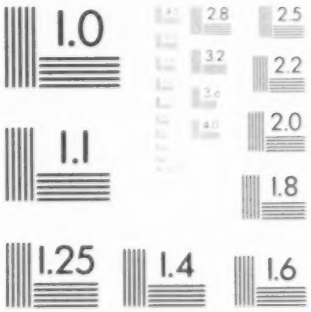

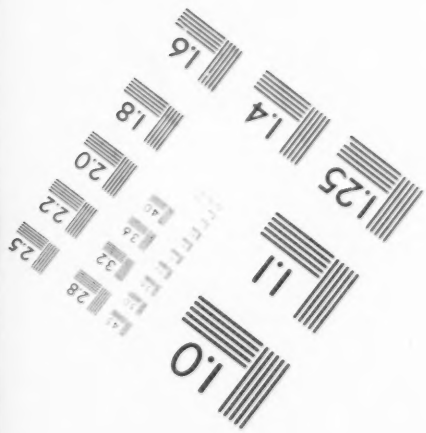

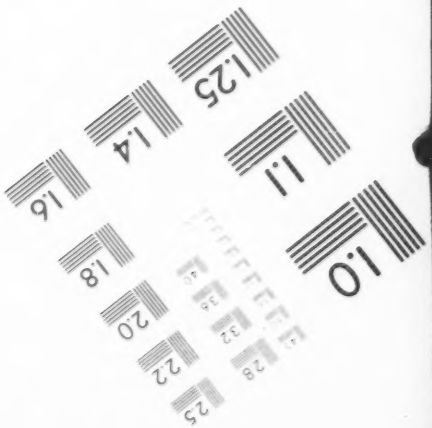

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RESOURCES

This listing is not to be construed as explicit or implicit departmental approval for use of the resources listed. The writers have provided these titles as a service only, to help school authorities identify resources that contain potentially useful ideas. The respo sibility to evaluate these resources prior to selection rests with the user, in accordance with any existing local policy.

Resources listed in this section can be ordered from local bookstores and/or publishers/distributors. See pages 197–198 for addresses for publishers/distributors.

Community Resources

Canadian Mental Health Association
#328, 9707 – 110 Street
Edmonton, AB T5K 2L9
Telephone: (780) 482–6576
Web site: http://www.mentalhealth.com

Print Resources

1–2–3 Magic: training your children to do what you want (1995) by Thomas W. Phelan. Glen Ellyn, IL: Child Management, Inc. ISBN 0–9633861–2–3 (book); ISBN 0–9633861–3–1 (video). ECS–Grade 8.

This book describes the 1–2–3 or counting method for managing the behaviour of students in ECS – Grade 8. It provides strategies to help teachers and parents reduce obnoxious and encourage appropriate behaviours, respond to major/medium/minor behaviour offences, build self-esteem and improve active listening skills. A video is also available.

Administrative intervention: a school administrator's guide to working with aggressive and disruptive students (1993) by Donald D. Black & John C. Downs. Longmont, CO: Sopris West Inc. ISBN 0–944584–57–8. Grades 6–12.

This handbook for school administrators outlines strategies for dealing effectively with students who are aggressive and disruptive. It offers suggestions for de-escalation and outlines a model of information gathering and on-the-spot social skill training that could include how to follow instructions, how to accept criticism or a consequence, how to accept "No" for an answer, how to make a request, how to get the teacher's attention or how to greet someone. Subsequent chapters include student apologies, behaviour contracting and in-school suspensions. The summary includes a short discussion of special cases and six rules for an administrative intervention.

Back off, cool down, try again: teaching students how to control aggressive behavior (1995) by Sylvia Rockwell. Reston, VA: The Council for Exceptional Children. ISBN 0–86586–263–X.

This book uses classroom dynamics to help students move through the developmental stages of social interaction. The author offers teaching procedures for social skill instruction and increasing student self-awareness, self-control, self-reliance and self-esteem. The focus moves from teacher control to control through peer interaction. The resource presents practical strategies for group management; affective and academic instruction; and planning, documentation and consultation. The appendices include a list of affective and academic instructional resources, reinforcement activities, behaviour management forms, planning forms and examples of themed instructional units.

Best practices — behavioral and educational strategies for teachers (1996–1997) by H. Kenton Reavis, Stevan J. Kukic, William R. Jenson, Daniel P. Morgan, Debra J. Andrews & Susan L. Fister (eds.). Longmont, CO: Sopris West Inc. ISBN 1–57035–052–3. Grades 1–12.

Based on a program developed by the Utah State Office of Education, *Best Practices* offers teachers condensed descriptions and outlines of 12 educational practices. Through techniques such as over-correction, contracts, home notes, group contingencies, peer tutoring and time out, teachers can improve students' motivation, cooperative learning, academic performance and behaviour within the classroom. This resource also includes reproducible tools and handouts for implementing the strategies.

Classroom management: a thinking and caring approach (1994) by Barrie Bennett & Peter Smilanich. Toronto, ON: Bookation Inc. and Edmonton, AB: Perceptions. ISBN 0–9695388–1–2. Available from the Teachers' Book Depository.

The authors discuss the complexity of school discipline and analyze what effective and not-so-effective teachers do. The authors link unsatisfied needs with misbehaviour and outline steps for preventing misbehaviour by creating environments where students belong. The role of instructional skills, cooperative learning and conflict-resolution techniques are discussed, as well as ways to start the school year. Final chapters deal with handling misbehaviours through low-key responses, squaring off, giving choices, defusing power struggles, informal agreements and formal contracts. The process and pitfalls of establishing school-wide discipline policies are discussed, as well as recent research on effective schools.

Esteem builders: a K–8 self esteem curriculum for improving student achievement, behavior and school climate (1989) by Michelle Borba. Torrance, CA: Jalmar Press. ISBN 0–91519053–2. ECS–Grade 8. Available from the Teachers' Book Depository.

An ECS–Grade 8 program that uses five building blocks of self-esteem (security, selfhood, affiliation, mission, competence) as a base. Includes over 250 grade-level, curriculum-content, cross-related activities, assessment tools and a checklist of educator behaviours for modelling. Contains instantly usable award designs for certificates, buttons and posters, a 40-week lesson planner and extensive bibliography.

Helping kids handle anger: teaching self control (1988) by Pat Huggins & Judy Williams. Longmont, CO: Sopris West Inc. ISBN 0–944584–96–9. Grades 1–6.

This manual is a guide for teaching elementary students social skills. Each field-tested lesson includes background theory, a script, practice activities, transparency masters and reproducible worksheets, and supplementary activities. Lessons include recognizing anger as a normal feeling, using self-talk, expressing anger in an assertive, socially acceptable manner, four steps for controlling anger, dealing with frustration, directing anger appropriately, using "I-messages," responding to a peer's anger, accepting criticisms and handling put-downs. The appendices include art and writing activities, additional teacher resource materials, and pretests and post-tests on lesson concepts.

Interventions: collaborative planning for students at risk (1993–1997) by Randall S. Sprick, Marilyn Sprick & Mickey Garrison. Longmont, CO: Sopris West Inc. ISBN 0–944584–95–0.

This comprehensive resource consists of two components to help educators plan and implement strategies for at-risk students. The procedural manual provides information on how to design and implement high-quality intervention plans. The 16 self-contained booklets contain proven interventions with step-by-step instructions for implementing, monitoring and fading a specific intervention. The intervention booklets include procedures, such as managing physically dangerous behaviour, managing severely disruptive behaviour, self-monitoring, self-control, training, restructuring, self-talk, academic assistance and managing stress. Twenty optional audiotapes are available.

Room 14: a social language program (1993) by Carolyn C. Wilson. East Moline, IL: LinguiSystems, Inc. ISBN 1–55999–255–7. Grades 1–5.

Room 14, for ages 6–10, includes an activity book, instructor's manual and picture book. It is a curriculum resource which integrates easily into a language arts program with stories, comprehension questions and activities for making and keeping friends, fitting in at school, handling feelings, using self-control and being responsible. Lessons are well-organized and well-planned.

Skillstreaming the elementary school child: new strategies and perspectives for teaching prosocial skills (1997) by Ellen McGinnis & Arnold P. Goldstein. Champaign, IL: Research Press Company/Colwell Systems. ISBN 0–87822–372–X. Grades 1–6. Available from the Learning Resources Distributing Centre.

This resource addresses social skill deficiency and its remediation through the prosocial skills training approach called Skillstreaming. The curriculum is divided into five skill groups: classroom survival skills, friendship-making skills, skills for dealing with feelings, alternatives to aggression and skills for dealing with stress. Within each skill group, strategies are provided for teaching elementary school children 60 specific prosocial skills; e.g., asking for help, saying thank you, using self-control, accepting consequences, making a complaint, dealing with group pressure.

The Teacher's encyclopedia of behavior management: 100 problems/500 plans (1995) by Randall S. Sprick & Lisa M. Howard. Longmont, CO: Sopris West Inc. ISBN 1–57035–031–0. ECS–Grade 9.

This reference book contains approximately 100 common classroom problems arranged alphabetically by title. Each problem includes general considerations, model plans, and suggested steps for developing and implementing a plan. The appendices deal with three topics: reinforcing appropriate behaviour, assigning responsibilities or jobs and responding to inappropriate behaviour. An index includes multiple descriptive titles for each problem.

Teaching for student differences (1995), Book 1 of the *Programming for Students with Special Needs* series by the Special Education Branch of Alberta Education. Edmonton, AB: Alberta Education. ISBN 0–7732–1834–3. ECS–Grade 12. Available from the Learning Resources Distributing Centre.

Highlights strategies for differentiating instruction within the regular classroom for students who may be experiencing learning or behavioural difficulties, or who may be gifted and talented. It also describes a process for modifying the regular program and includes forms to assist in teacher planning.

Teaching students with learning disabilities (1996), Book 6 of the *Programming for Students with Special Needs* series by the Special Education Branch of Alberta Education. Edmonton, AB: Alberta Education. ISBN 0–7732–1799–1. ECS–Grade 12. Available from the Learning Resources Distributing Centre.

This resource provides practical strategies for regular classroom and special education teachers. Section one discusses the conceptual model and applications for the domain model. Section two includes identification and program planning, addressing early identification, assessment, learning styles and long-range planning. Section three contains practical strategies within specific domains including metacognitive, information processing, communication, academic and social/adaptive. Section four addresses other learning difficulties, including attention-deficit/hyperactivity disorder and fetal alcohol syndrome/possible prenatal alcohol-related effects. The appendices contain lists of annotated resources, test inventories, support network contacts and blackline masters.

The Tough kid tool box (1994) by William R. Jenson, Ginger Rhode & H. Kenton Reavis. Longmont, CO: Sopris West Inc. ISBN 1–57035–000–0. Grades 1–8.

This resource complements and supplements *The Tough Kid Book* by providing in-depth explanations and techniques that teachers can use in everyday situations. The sections include:

- mystery motivators (incentive systems designed to deliver random rewards for appropriate behaviours)
- home note program (informational note that goes from classroom to home, and back to school)
- self-monitoring program (a process in which students observe and collect data on their own behaviours)
- behaviour contracting (involves placing contingencies for reinforcement into a written document which is agreed to and signed by all parties)
- tracking procedures (monitoring students' behaviours and academic performance)
- unique reinforcers (positive reinforcement is given to students immediately after desired behaviours occur)
- general interventions (variety of interventions with detailed instructions for use).

Each section begins with a definition of the intervention, a specific description of the intervention and complete steps for implementing the technique. Trouble-shooting suggestions and "making it even better" suggestions are offered as well. The purchasing teacher has permission to reproduce the tools for use in the classroom.

Video Resources

Anger: you can handle it (1996) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. Grades 7–12.

This video for high school students follows several teenagers as they experience and discuss anger. The video looks at anger triggers and anger styles — ways in which people express their anger, and ways to take positive action. It emphasizes that regardless of what makes us angry, we are always responsible for our own actions. The video presents a three-step process: cool off, assess the situation and take constructive action. This resource also includes a teacher's guide.

As tough as necessary: a discipline with dignity approach to countering aggression, hostility, and violence (1997) by the National Education Service. Bloomington, IN: National Educational Service. Available from the Learning Resources Distributing Centre.

This kit extends the original *Discipline with Dignity* program developed by Richard Curwin and Allen Mendler. It focuses on techniques for handling power struggles, student conflicts and difficult groups of students, including gangs. The cornerstone of this program is that all students, no matter how challenging their behaviour, deserve to be treated with respect and dignity, and that all discipline should be designed to teach responsibility rather than just obedience. *As Tough As Necessary* contains four 20-minute videos, filmed in ECS–Grade 12 multicultural settings to provide strategies for prevention, intervention and resolution of difficult discipline situations. Each video includes interviews, expert analysis and scenarios that depict conflicts arising in and outside of classrooms. The accompanying 70-page training guide outlines different training sessions.

BeCool (series) (1999) by James Stanfield Publishing Company. Santa Barbara, CA: James Stanfield Publishing Company.

The goal of this video program is to develop the key elements of emotional intelligence: impulse control, empathy and self-awareness. Within the context of teaching assertiveness, *BeCool* teaches students specific reflective thinking techniques to promote self-control and interrupt the tendency to impulsively act out. There are six programs that cover all grade levels.

- The K–Grade 3 program is *BeCool: Coping with Difficult People*. Chester the cat and his real-life friends teach BeCool techniques that help younger students cope with teasing, bullying, criticism and anger.
- The Grade 3–6 program teaches students to avoid the negatives of "hot" and "cold" behaviour.
- *BeCool: Losing It!* teaches the latest cognitive and self-talk techniques for controlling impulsive, self-destructive and violent behaviour to students in Grades 5–7.

- The middle school program targets students in Grades 6–9. *Part 1 — BeCool: Coping with Difficult People* teaches techniques for coping and defusing provocation and aggression. *Part 2 — BeCool: Give and Take — Negotiate* illustrates techniques used by international negotiators and teaches adolescents how to negotiate long-term resolution of disputes with peers and authority figures.
- The high school program, *BeCool: Coping with Difficult People* teaches students how to control their emotions in tough situations, without losing dignity and respect.
- The total program of all six *BeCool* packages includes 68 student videotapes, five Chester cartoon videotapes, Chester puppet, 18 parent/teacher tapes and 27 teacher's guides. An interactive CD-ROM of *Chester and the Secret of Cool* is also available.

I Can make good choices (1995) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. Grades 2–4.

Children learn the steps involved in making a decision: understanding the options, predicting the outcomes and living with the consequences. The teacher's guide provides guidelines and questions for classroom discussion, suggested related activities and instructions for using the accompanying activity sheets. This resource could be useful for small groups or for the whole class. This resource includes a 17-minute video, student worksheets and a teacher's guide.

I Get so mad (1993) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. ECS–Grade 2.

When young children get angry, their strong feelings can propel them into inappropriate or destructive behaviour. *I Get So Mad* makes students aware that anger is a natural emotion that everyone experiences at times. It helps them understand that it is not the "getting mad" that matters, but rather what they decide to do about it, that counts. This program offers children easy-to-understand ways of coping with anger. Includes a 13-minute video, student worksheets, audiocassette and teacher's guide.

Solving conflicts — student workshop (1994) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. Grades 2–5.

This kit is designed as a hands-on workshop. The video presents scenarios and focuses on the skills of getting the facts, listening, expressing feelings and brainstorming. Since conflict resolution is often difficult to achieve, the techniques shown are not guaranteed to work. This resource should be used with other materials that portray people with disabilities and Aboriginal people solving conflicts. Other components include a teacher's guide and student worksheets.

Straight talk II: violent times (1996) by Attainment Company, Inc. Verona, WI: Attainment Company, Inc. Grades 7–12. Available from Sunburst Communications.

This series is the sequel to the popular award-winning video series *Straight Talk*. *Straight Talk: Violent Times* features the frank testimonials of 13 teens who have been exposed to violence in their daily lives. Some are perpetrators, some are victims and some, witnesses. Many were victimized early in life and acted out violently themselves as they entered their teens. Now they are learning to cope with their past and prepare for a more positive future. The series includes three, 25-minute videotapes: *A Time of Rage*, *A Time of Grief* and *A Time for Healing*. This resource includes a discussion guide.

Ten things to do instead of hitting (1995) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. ECS–Grade 2.

Targeted at children in ECS–Grade 2, this video features four short, realistic vignettes and music videos that show children dealing with angry feelings that have been triggered by a variety of situations. The goal of this video is to help children recognize, name and deal with emotions, and build a repertoire of acceptable alternatives that allows them to defuse anger and hostility without resorting to aggression. Other components include an audiocassette, a teacher's guide and student worksheets.

What to do about anger — student workshop (1997) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. Grades 2–4.

What To Do About Anger is designed as a hands-on workshop in anger management skills. The premise is to help children get along better with friends, family and adults. The program teaches children the difference between angry feelings and angry behaviours, how to handle anger by controlling how they act, and how to deal with angry energy in a safe and positive way. Includes a 16-minute video, student worksheets and teacher's guide.

When anger turns to rage (1995) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. Grades 5–9.

This video is addressed to upper elementary and junior high students. It examines anger from the student's point-of-view, using real-life circumstances. It introduces a variety of practical anger management skills young people can use in day-to-day situations. It shows students that there are safe, nondestructive ways of expressing and dealing with this complex human emotion. The video also stresses that anger can be a powerful way of motivating people to seek positive change and that students can channel their anger to achieve constructive goals. Includes a 27-minute video and teacher's guide.

When you're mad, mad, mad! (1993) by Sunburst Communications. Pleasantville, NY: Sunburst Communications. Grades 5–9.

For middle school students, the loss of control that anger provokes is alarming and can undermine their self-esteem. This video helps students understand that anger is normal, and helps them differentiate between angry feelings and angry behaviours. It shows students how they can handle anger and control how they act. It also suggests positive steps to take. This resource includes a teacher's guide.

Student Resources

Canadian Mental Health Association
#328, 9707 – 110 Street
Edmonton, AB T5K 2L9
Telephone: (780) 482–6576
Web site: http://www.mentalhealth.com

Publisher/Distributor Addresses

Child Management, Inc.
800 Roosevelt Rd.
Glen Ellyn, IL 60137
U.S.A.
Telephone: (630) 790–9600

Council for Exceptional Children
1920 Association Drive
Reston, VA 20191–1589
U.S.A.
Telephone: 1–888–232–7733 or (703) 620–3660
Fax: (703) 264–9494
Web site: http://www.cec.sped.org/index.html

James Stanfield Co., Inc.
Drawer WWW
P.O. Box 41058
Santa Barbara, CA 93140
U.S.A.
Telephone: 1–800–421–6534
Fax: 1–805–897–1187

Learning Resources Distributing Centre, Alberta Learning
12360 – 142 Street
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Telephone: (780) 427–5775
Fax: (780) 422–9750
Web site: http://www.lrdc.edc.gov.ab.ca/

LinguiSystems, Inc.
3100 – 4th Avenue
East Moline, IL 61244–9700
U.S.A.
Telephone: 1–800–PRO IDEA (776–4332) or (309) 755–2300
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Web site: http://www.linguisystems.com

Sopris West Inc.
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The Teachers' Book Depository
18004 – 116 Avenue
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Telephone: 1–800–661–1959
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Web site: http://teachersbooks.epsb.net

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Fax: (780) 451–3958
Web site: http://teachersbooks.epsb.net

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Counseling Today Online by American Counseling Association at web site [http://www.counseling.org/ctonline/archives/conduct.html]

Internet Mental Health at web site [http://www.mentalhealth.com]

Knowledge Exchange Network by Center for Mental Health Services (U.S.A.) at web site [http://www.mentalhealth.org/child/CONDUCT.HTML]

New York Online Access to Health (NOAH) at web site [http://www.noah.cuny.edu/illness/mentalhealth/cornell/conditions/conductd.html]

Research and Training Center on Family Support and Children's Mental Health, Portland State University at web site [http://www.rtc.pdx.edu/resource/conduct.html]

School of Psychology, University of Wales Bangor at web site [http://www.psych.bangor.ac.uk./deptpsych...ses/p3h02/ConductDisorderOverheads.html]

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Evaluation and Feedback

We hope *Teaching Students with Emotional Disorders and/or Mental Illnesses* addresses most of your questions and concerns regarding providing appropriate programs for students with emotional disorders and/or mental illnesses. Since the users of this resource are in the best position to identify the strengths and weaknesses, please take some time to share your thoughts with us. If you have further suggestions and comments on the use and value of this resource, please feel free to add those comments below and forward your feedback to the Special Programs Branch, Alberta Learning.

How do you rate *Teaching Students with Emotional Disorders and/or Mental Illnesses*?

	Yes	No	Comments
Useful?	❑	❑	_____
			_____
Easy to understand?	❑	❑	_____
			_____
Well-organized?	❑	❑	_____
			_____
Complete?	❑	❑	_____
			_____

Overall rating 5 (Excellent) 4 3 2 1 (Poor)

Other comments: _____

_____

_____

_____

_____

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